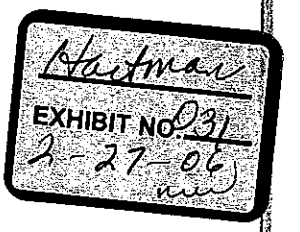
Exhibit 51

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS



IN RE:	)	
	)	
PHARMACEUTICAL INDUSTRY	)	Civil Action No.
AVERAGE WHOLESALE PRICE	)	01CV12257-PBS
LITIGATION	)	

HIGHLY CONFIDENTIAL
DEPOSITION
of JOE SPAHN

Taken at Anthem
4361 Irwin Simpson Road
Mason, Ohio 45040
on November 30, 2004, at 9:12 a.m.
Reported by: Rhonda Lawrence, RPR/CRR

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STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of JOE SPAHN, the Witness herein, called by the Defendants, under the applicable Rules of Federal Civil Court Procedure, may be taken at this time by the notary pursuant to notice; that said deposition may be reduced to writing in stenotypy by the notary, whose notes thereafter may be transcribed out of the presence of the witness; and that the proof of the official character and qualification of the notary is waived.

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JOE SPAHN
being first duly sworn, as hereinafter certified, deposes and says as follows:
EXAMINATION
BY MR. MANGI:
Q. Good morning, Mr. Spahn.
A. Good morning.
Q. As I said, my name is Adeel Mangi. I'm from the law firm of Patterson, Belknap, Webb & Tyler. We represent the defendant drug manufacturers in this case.
MR. MANGI: Before we begin, pursuant to a conversation I just had with counsel for Anthem, we're going to designate this deposition transcript and the transcripts for all Anthem witnesses we'll be taking over the next couple of days as highly confidential pursuant to the protective order. And we can revisit that as to sections as necessary in the future.
MR. THOMAS: Great.
Q. Mr. Spahn, thank you for taking the

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time to speak with us today. Have you ever been deposed before?
A. I don't believe so. I don't ever recall having, like, a court reporter. So I think the answer's no.
Q. Okay. Let me just run through some of the standard ground rules for a deposition, then.
The first is, it's important that you answer all questions verbally so that the court reporter can take down your answers. She can't take down a nod of the head or shrug of the shoulders. Okay?
A. (Indicates affirmatively.)
Q. And you'll have to answer that verbally.
MR. THOMAS: Say okay.
A. Oh. Okay.
Q. Just so she can write it down.
If at any point a question that I ask you is unclear, please stop me and tell me that, and I'll do my best to rephrase it.

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A. All right.
Q. If at any point during the deposition you'd like to take a break, please let me know, and as soon as possible, we'll take a break.
A. All right.
Q. What is your current job title, Mr. Spahn?
A. My current job title is senior health care consultant.
Q. And who's your employer?
A. Anthem Blue Cross/Blue Shield.
Q. Is your work focused on a particular region?
A. Anthem Midwest.
Q. What states fall within that area of responsibility?
A. Ohio, Kentucky and Indiana.
Q. How long have you been in this position?
A. Since 1992.
Q. And you've held the same title,

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senior health care consultant, since 1992?
A. Yes.
Q. Is that when you joined Anthem?
A. No.
Q. When did you join Anthem?
A. I joined Anthem in April of '87.
Q. We'll go through your employment history from '87 to the present in the moment.
But first, perhaps you could describe for me your educational background after high school.
A. I have a bachelor's in accounting and an MBA in finance.
Q. When did you get your bachelor's in accounting?
A. I got my bachelor's in 1972.
Q. Where did you get that qualification?
A. University of Cincinnati.
Q. And the MBA?
A. From Xavier University, in 1982.

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Q. After receiving your bachelor's qualification, did you take up full-time employment?
A. Yes.
Q. Where did you start working?
A. My first employment was with Schelle Distillers.
Q. How long were you at that company?
A. One year.
Q. Is that an alcohol --
A. Yes.
MR. THOMAS: Do you want to spell that for the court reporter. She'll ask you anyway.
A. I think it's S-c-h-e-l-l-e. I believe.
MR. THOMAS: Okay. I didn't know if it was Schoenling Brewing Company or Schelle. Go ahead.
Q. They didn't manufacture any medical products, did they?
A. No.

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Q. Depending on your definition of medical, I suppose.
Were you employed there as an accountant?
A. Yes.
Q. You left that job in 1973?
A. Yes.
Q. Where did you move to in '73?
A. To National Distillers and Chemical Corporation.
Q. How long were you employed there?
A. Until I left there in 1987.
Q. What job title did you begin -- did you start with at National Distillers and Chemical Corporation?
A. I don't know about the job title. I worked in cost accounting. So I was like a cost analyst.
Q. Okay. Did you remain in that department until 1987?
A. Yes.
Q. Okay. Was your area of

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responsibility still cost accounting throughout that time period?
A. Yes.
Q. Did National Distillers and Chemical Corporation manufacture or sell any medical products?
A. Not that I know of.
Q. During the time you were employed there, you received your MBA qualification, correct?
A. Yes.
Q. Was that a part-time course of study?
A. Yes. I went to evening college.
Q. Then in 1987, you left National Distillers and Chemical Corporation and came over to Anthem; is that correct?
A. That's correct.
MR. THOMAS: Can we go off the record for just one second.
(Discussion is held off the record.)
BY MR. MANGI:

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Q. Let's just clarify. The entity that you joined in 1987, what was it called at that time?
A. Community Mutual Insurance Company.
Q. At some point in the future, did the name of Community Mutual Insurance Company change to something else?
A. Yes.
Q. When did that name change take place?
A. I believe it was -- I believe it was '95 or '96. I don't know exactly.
Q. Okay. What did the name change to in '95 or '96?
A. Anthem.
Q. Is that Anthem Blue Cross/Blue Shield?
A. Again, I'm not sure if we're officially called Anthem Blue Cross/Blue Shield or if it's Anthem Enterprise or Anthem, Incorporated.
Q. You know it as Anthem?

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A. Yes.
Q. Have there been any subsequent name changes since '95?
A. Not that I'm aware of.
Q. So in 1987, when you joined Community Mutual Insurance Company, what was your title?
A. When I started -- I started in the cost and budgeting department. So I started in the finance department.
Q. Okay.
A. So I think the title may have been something like cost and budget analyst.
Q. Okay. How long did you remain in that position?
A. Until '91.
Q. What were your responsibilities in that position?
A. Basically, we did the -- we did cost analysis. Basically, I did it for the automotive accounts.
Q. Anything else?

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A. No. That was -- that was it.
Q. Okay. When you refer to cost accounting or cost analysis, what are you referring to there? What are the components that would go into that analysis?
A. Well, they looked at the administrative expense and how it was allocated to the auto accounts.
Q. By "administrative expense," what do you mean?
A. Well, the overhead expenses. This is all the various departments, like how much of the -- what am I trying to say? The claims processing area, how much that got allocated to GM, various other overhead.
Q. Okay. Was this limited to analysis of overhead costs?
A. Yes.
Q. Did any of your analysis involve the study of drug reimbursement costs?
A. No.
Q. Did any of your analysis include the

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study of drug acquisition costs?
A. No.
Q. Was there any analysis at all that related to any sort of price or reimbursement amount for drugs?
A. No.
Q. So you remained in this position until 1991, correct?
A. Correct.
Q. In 1991, did your position change?
A. Yes.
Q. What did you move to in 1991?
A. I moved to the HMO, the health care organization. It was a division of Community Mutual.
Q. Prior to that time, when you were in your cost analysis position, were you studying only automotive insurance?
A. Can you say that again?
Q. Yeah. I just want to clarify.
When you mentioned earlier that you were in the cost and budgeting finance

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department doing cost analysis, did that involve analysis relating to health care products or another type of insurance?
A. I'm still not sure if I understand the question.
Q. You mentioned that when you were doing cost analysis you were focusing on automotive accounts.
A. Right.
Q. My question is: Did you mean by that study relating to health care provided to automotive companies or were you talking about car insurance?
A. Well, health care insurance.
Q. Okay. I just want to make sure I didn't misunderstand you.
So in 1991, you moved to the HMO division?
A. Right.
Q. And what title did you -- or what position did you move into?
A. Physician reimbursement analyst.

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Q. How long did that remain your title, physician reimbursement analyst?
A. For one year.
Q. What were your responsibilities in that position?
A. I analyzed the physician fee schedules for the HMO products.
Q. What sort of analysis was this?
A. Basically, it was cost of care analysis. In other words, what the impact would be if we increase or decrease fees.
Q. Did you see this as an accounting-related position?
A. I saw it as a financial-related position.
Q. So it was financial analysis?
A. Yes.
Q. Was any component of your analysis there based on physicians' acquisition costs for drugs?
A. No.
Q. So you were studying only the

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amounts that Anthem reimburses physicians; is that correct?
A. Correct.
Q. That presumably included reimbursement for services as well as reimbursement for drugs; is that correct?
A. It would include drugs that are administered in a physician's office.
Q. Okay. So that was included, together with study of service cost?
A. Yeah.
Q. Now, did the analysis pertain to a general survey of an ongoing survey of options, or was there a specific project that you were with?
A. No. It was more like ongoing.
Q. And what sort of an impact were you looking at relating to changes in the fee schedule? Was it purely financial?
A. Purely financial.
Q. So how much more would Anthem pay if it increased fee schedules, something like

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that?
A. Correct.
Q. During that one year when you were in this position, did you carry out any other kinds of analysis?
A. No.
Q. In 1992, did you move to another position?
A. Well, what happened, the HMO division, which was called HMP, that division was absorbed back into the corporation.
Q. Okay. So did your position change or your title?
A. Yes, because then they started calling me the senior health care consultant.
Q. Did your responsibilities change?
A. Yes. Well, they expanded.
Q. How long did you remain a senior health care consultant?
A. Until present.

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Q. Okay. Have your responsibilities, after the initial expansion -- have they remained the same?
A. Yes.
Q. So what was that expansion of your responsibilities?
A. Well, because I was doing physician fee schedule analysis just for the HMO product, and then after that division was merged back into the corporation, I was doing it for all products, not just HMO products, but all products.
Q. And what sorts of products are you referring to there?
A. Basically, you have traditional, sometimes called indemnity; you have point of service; preferred provider organizations, PPOs; and then also HMOs.
Q. Other than the area of your responsibility being encompassed to these different types of plans, were there any other expansions in your responsibilities in

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1992?
A. No.
Q. What about the type of analysis you were being asked to perform, did that remain the same?
A. Yes.
Q. Is that the same sort of analysis you're carrying out today?
A. Yes.
Q. Again, that involves study of the financial impact of Anthem of changes in its fee schedule; is that correct?
A. Correct.
Q. In your current position, since 1992, have you carried out any types of analyses other than that studying the financial impact of changes in the fee schedule?
A. No.
Q. Now, in your current position, are you part of a particular department or division within Anthem?

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A. Yes. There is a division called health care management, so I'm part of that division.
Q. What is the focus of that division?
A. Health care management is basically involved in contracting with hospitals and physicians, setting reimbursement, cost of care trends.
Q. Anything else?
A. I think that's basically it.
Q. Who do you report to in this health care management division?
A. I report to Flo Buendia.
Q. Could you spell her name for the court reporter, please.
A. I'm sorry. It's a he.
Q. I'm sorry.
A. It's actually Florentine. I'm sorry.
MR. THOMAS: B-u-e-n-d-i-a.
A. Yeah. Buendia is his last name.
Q. And what is his title?

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A. I guess Flo is manager of contracting and reimbursement.
Q. Do you know who he reports to?
A. Yes.
Q. Who does he report to?
A. He reports to Dave Prugh.
Q. Is that P-r-u?
A. P-r-u-g-h.
Q. And what is Mr. Prugh's position?
A. I'm not sure exactly what his proper title is, but Dave is something like executive director, but I'm not sure exactly. He's executive director, but I don't know his exact title.
Q. Now, the contracting work that goes on in the health care management department, do you have any involvement with that?
A. I have no involvement with contracting.
Q. Are you knowledgeable about the contracting process?
A. I know something about the process,

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yes.
Q. Are you knowledgeable about the negotiation, if any, that's involved in the contracting process?
A. Somewhat, yes.
Q. How about the setting of reimbursement, are you involved in setting reimbursement rates?
A. Yes.
Q. What is your responsibility in relation to setting of reimbursement rates?
A. I support the health service areas in developing and analyzing the fee schedules and cost trends.
Q. We talked about the work of the health care management department. We talked about contracting, setting reimbursement and cost trends.
A. Yes.
Q. What did you mean by "cost trends"?
A. Pretty much what it says. Whether the health care cost trends are going up or

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down or staying even.
Q. Just financial analysis?
A. Yes.
Q. Now, what did you do in preparation for your deposition today?
A. Almost nothing.
MR. THOMAS: Thanks a lot.
Q. Other than conversations with counsel, did you speak to anyone else?
A. No.
Q. Did you review any documents in preparation for your deposition?
A. No.
Q. Okay. And are you currently a member of any industry associations?
A. No.
Q. Or professional organizations?
A. No.
Q. Do you subscribe to any periodicals that relate to the health care industry?
A. Well, as an employee of Anthem, I subscribe to a few, if that's what you mean.

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Q. What publications do you subscribe to?
A. We get Part B News, Medicare Part B News. We have to get the Federal Register. Part B News and the Federal Register is basically it.
Q. Do you review those publications as part of your job responsibilities?
A. Yes.
Q. Both of them?
A. Yes.
Q. Are you familiar with any publications that report drug prices?
A. Yes.
Q. What sort of publications are you familiar with?
A. There's one called RedBook.
Q. Are you familiar with any others?
A. There is the -- I guess I'm not really familiar. I've heard the term Medi-Span, but I've never used it or looked at it, so I'm not real sure what that is.

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Q. Are you familiar with the First DataBank?
A. No.
Q. Do you subscribe to RedBook or do you know of others that subscribe to Redbook?
A. I don't personally, but I know the company subscribes to it.
Q. Do you utilize Redbook in your position?
A. No.
Q. Do others in your department use Redbook, that you're aware of?
A. Not that I'm aware of.
Q. Have you ever looked at Redbook?
A. I've seen one, yes.
Q. Do you know what's reported in Redbook?
A. Yes, generally.
Q. What's your understanding of the information that's contained within Redbook?
A. Redbook lists names of drugs, their

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national drug code number, and then they list the size, the dose, doses allowed, et cetera, et cetera, and then they'll list average wholesale price, and often they list the direct price.
Q. I'm sorry, did you say direct price?
A. Direct price.
Q. Anything else that you're aware of?
A. No.
Q. Are you familiar with the term "wholesale acquisition cost" or "WAC"?
A. Yes.
Q. What is your understanding of what WAC is?
A. My understanding of WAC is -- generally, represents more what is actually paid for the drug as opposed to, you know, the -- I guess the way it's presented to me, it's sort of like you have the list price, but then the negotiated price, what you actually pay for it.
Q. Do you understand WAC to be the same

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as or different from the direct price you referred to in RedBook?
A. I'm not real sure, but my perception is that WAC comes closer to the direct price.
Q. Now, going back to some broader issues. Does Anthem provide any services other than health insurance?
A. Lord. I believe so, but I'm -- I'm only involved in the health insurance part.
Q. Is it your understanding that the focus of the insurance business is on health care?
A. Yes.
Q. Do you have an understanding as to how many individuals across the country have insurance through Anthem?
A. No, I don't know that number.
Q. The different types of plans that you referred to, the indemnity plans, the HMO plans, do you have an understanding as to how many different products Anthem offers

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in total?
A. No, I don't know a total.
Q. Okay. Do individual insureds make co-payments, or does it vary from plan to plan?
A. Can you rephrase --
Q. Sure. Individuals who get their insurance through Anthem, does -- whether or not they will make a co-payment when visiting a doctor, does that vary from plan to plan?
A. I don't know.
Q. Okay. These are issues that are outside your area of responsibility?
A. Right.
Q. Do you know whether Anthem owns any physicians' practices?
A. No, I don't.
Q. Do you know whether Anthem owns any pharmacies?
A. I don't -- I mean, there's Anthem Prescription, the mail order pharmacy.

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Q. Right.
A. I'm not sure exactly what that relationship is. I'm not sure if Anthem owns it or part of it. I'm not sure.
Q. Leaving aside the mail order business, do you know if Anthem owns any retail pharmacies?
A. I don't know.
Q. Do you know whether Anthem has ever -- withdraw that.
At present, does the amount that Anthem reimburses physicians for drugs that are administered in office vary from area to area or plan to plan, or is it uniform across the country?
A. Across the country?
Q. Right.
A. I don't know about across the country. I can only talk about Midwest.
Q. Okay. How about in the Midwest?
A. Yes, it's going to vary, because it's a local --

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Q. Okay. Now, at present, in the Midwest, how many different methodologies are used to calculate the amount Anthem will reimburse physicians in relation to drugs administered in office?
A. There's only one.
Q. What is that methodology?
A. Percent of Medicare.
MR. MATT: I'm sorry. Did you say percent of Medicare?
THE WITNESS: Percent of Medicare's drug fee schedule.
MR. MATT: Thank you.
Q. At present, what is that percentage?
A. It will vary somewhat, but in general, it's going to be in the range of -- from 100 percent to -- let me rephrase that. Let's say it's from 90 percent to maybe 120 percent.
Q. How long has the percentage of Medicare been the methodology that Anthem uses to calculate the amount it will

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reimburse physicians for drugs administered in office?
A. Since we -- since we actually first came out with the fee schedule for drugs.
Q. Do you know when that was?
A. I can tell you it was approximately around '93 or '94.
Q. Okay. Now, you're referring here to Anthem Midwest?
A. Well, in '93 or '94, there was only Community Mutual Insurance Company.
Q. Okay. Are you referring to the Midwest region only?
A. Yes. For me, yes.
Q. Okay. Is all of your knowledge focused on what's been happening in the Midwest region as opposed to nationally?
A. Yes.
MR. THOMAS: I'm going to just interject an objection based upon clarification. You're dealing with a very transitional time frame for our company. In

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that time frame, you're dealing with a man who worked solely for Community Insurance, which was local in Ohio, into a national-size corporation within a span of two years. So you need to be very specific about which date you're referring to when you're talking about this.
MR. MANGI: Okay.
Q. Let's clarify that. Community Mutual introduced a fee schedule in '93 or '94, right?
A. Right.
Q. And that was based on a percentage of Medicare fee schedule, correct?
A. Right.
Q. Later, around '95 or '96, Community became Anthem; is that correct?
A. Correct.
Q. Do you know whether that was simply a name change or did it become part of another organization?
A. That might be more of a technical

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question than I can answer.
Q. The question is only if you know.
A. I don't know.
Q. Okay. Is it your understanding that after that transition was complete, the methodology remained a percentage of the Medicare fee schedule?
A. Yes.
Q. And that's remained the case up until the present; is that correct?
A. Yes.
Q. Now, the percentage range that you described earlier as being in place today, 90 to 120 percent of Medicare fee schedule, has that been the approximate range since 1993, or has it changed over time?
A. No, it's changed.
Q. What was the range in '93?
A. It was approximately 130 to 140. I'm sorry. 130 to 140 percent.
Q. How would you characterize the changes over time in those percentage

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numbers?
A. I'm sorry?
Q. Sure. Let me clarify.
Were there a series of gradual shifts in those percentages, or were there a few points you can pinpoint when there were large shifts?
A. They were gradual shifts.
Q. Now, at present, the methodology is a percentage of the Medicare fee schedule. Do you know how the Medicare fee schedule is calculated?
A. I know there's been a lot of changes. I believe at one time they paid something like 100 percent of AWP, more or less. I think they actually varied by drug a little bit. I know it was 95 percent -- in general -- I think they made exceptions for drugs. In general, it was 95, then it went to 85 percent of AWP.
Now they're doing away with AWP, and starting in 2005, they're going to use what

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they're calling average sales price plus six percent.
Q. So we're clear here, your understanding is that the Medicare fee schedule has moved from 100 percent of AWP to 95 to 85, and now will transition to an average selling price plus six percent?
A. Yes. That's correct.
Q. And Anthem's methodology has been a percentage of that amount?
A. That's correct.
MR. THOMAS: When you say "that amount," you're referring back to the Medicare --
MR. MANGI: The Medicare fee schedule.
MR. THOMAS: Just to make sure.
Q. Now, do you know why in '93 or '94 Community Mutual decided to peg their reimbursement amount to the Medicare fee schedule?
A. Yes.

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Q. Why was that?
A. Because prior to that, we used what's generally called UCR, reasonable and customary. But basically, that means you pay a percent of charge. If you don't have a fee schedule in place, then you pay a percentage of the bill charged.
Q. That was a percentage of the actual charge that a physician submitted; is that correct?
A. That's correct.
Q. Just to be clear on the methodology there, how would that play out? An individual would go to a doctor's office, and let's say he'd be administered a drug, who would then bill what to who; do you know?
A. In general, the physician would submit the claim to -- okay -- Community Mutual or to us.
Q. That's fine. And the amount that the physician would bill in relation to the

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drug that he administered to the patient, that would be the physician's usual and customary charge; is that correct?
A. It would be the physician's bill charge.
Q. By "physician's bill charge," you just mean the amount the physician is billing?
A. Correct.
Q. Do you know how the physicians would calculate the amount that they would bill?
A. No, I don't.
Q. So the system prior to the introduction of this methodology in '93, '94 involved the processing of actual invoices received from doctors; is that correct?
A. Correct.
Q. Do you have any sense of how many invoices that would have involved?
A. No, I don't.
Q. Would it be fair to say it would have been a very substantial number of

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invoices?
MR. THOMAS: Clarification. Over what period of time?
Q. We're talking about the '93 time period here.
MR. THOMAS: On an annualized basis, on a monthly basis?
Q. Any basis that you feel comfortable with.
MR. THOMAS: If you know.
A. I don't know number of invoices. On the physician reimbursement side, drugs are about three percent of total physician reimbursement.
Q. Now, what were some of the problems with that system that Community Mutual was looking to fix or improve upon by moving to a percentage of the Medicare fee schedule?
MR. MATT: Objection to form. No foundation.
Q. You can answer.
A. Because we have a responsibility to

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our members to try and hold their health care cost down, and so you needed something in place that would help control cost care trends. And you also want to make sure that you're competitive in the marketplace.
Q. Okay. Perhaps I can try to clarify my question.
I had asked you earlier why in 1993 Community Mutual moved to this methodology involving a percentage of the Medicare fee schedule, and your answer was that because prior to that time the methodology was a percentage of the actual bill charged. I'm trying to understand what were the reasons that led to that change from one methodology to another.
MR. THOMAS: Asked and answered.
Q. Now, was it purely a matter of controlling costs, as you just described, or were there other factors?
MR. THOMAS: Asked and answered. Go ahead.

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A. You guys are confusing me.
MR. THOMAS: Just ignore us. Unless I tell you to not answer the question, you can just let me make my objection and he can make his. You can go ahead and answer.
A. It was purely trying to control costs.
Q. Was any part of the decision to change methodologies based on convenience of processing?
MR. THOMAS: Objection. Asked and answered.
A. No.
Q. Did the change in methodology succeed in lowering or controlling costs?
A. Yes.
Q. Can you quantify the savings that resulted immediately after the implementation of the new methodology?
A. No. I don't know.
Q. But you are aware that there was a cost savings --

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A. Yes.
Q. -- realized by the change in methodologies?
A. Yes.
Q. Okay. Now, in '93, you said that the percentage of the Medicare drug fee schedule was 130 to 140 percent, correct?
A. Yes.
Q. And that has gradually moved over time to the current position where it's 90 to 120 percent of the Medicare fee schedule, right?
A. Correct.
Q. What are some of the factors that have led to that change?
A. The competitive marketplace.
Q. Would it be fair to say that the percentage discount of the Medicare fee schedule that is applied to determine reimbursement to specific providers is determined entirely by a competitive dynamic?

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A. Okay. I'm sorry. Can you say that again?
MR. MANGI: Sure. Would you mind reading back the question.
(Record read as requested.)
MR. THOMAS: I'm going to object. Form and foundation. Go ahead.
A. I'm going to say yes.
BY MR. MANGI:
Q. Now, let's go back again to the '93, '94 time period. The range of 130 to 140 percent of the Medicare fee schedule, what was the basis for the variations within that range? Do you understand my question?
A. Again, I'm going to -- our fee schedules are local, so it kind of depends on the competitiveness in that market area.
Q. Okay. When you say "fee schedules are local," what sort of a region does each fee schedule apply to?
A. Today, if I can give -- can I give an example?

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Q. Sure.
MR. THOMAS: Yeah, I suppose. Go ahead.
A. If you take Ohio, for example, Ohio has a fee schedule for the Cincinnati market, the Dayton market, and then there's a fee schedule for -- I'll just say northern Ohio, which is basically Columbus and north. We also -- but the fee schedules also will vary if it's indemnity product or if it's a managed care product.
Q. Let's talk first about the geographical variation. At present, are there three fee schedules that cover Ohio?
A. Ohio has -- the traditional indemnity schedule is statewide. Then there's a managed care schedule. I'm talking about PPO point of service and HMO. There's a managed care schedule for Cincinnati; there's a managed care schedule for Dayton; there's a managed care schedule for northern Ohio.

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Q. Okay. Do you have an understanding as to what the different -- how many different fee schedules were in place in Ohio in 1993?
A. In '93, there was only two schedules, because they were statewide. So you had a traditional schedule and a managed care schedule.
Q. Now, what's the basis for the different fee schedules for the traditional products as opposed to the managed care products?
A. Excuse me. You say the basis for the difference?
Q. Yeah. Why are there different fee schedules for those two products?
A. I'm not sure I can answer that one. That's probably more a question for the people who are doing the contracting.
Q. Okay. Let's go back to the -- again, the '93 time schedule and the 130 to 140 range that you described. Is it your understanding that there was one type of product at 130 and another at 140, or was there variation falling at different points within that range?
A. No. It would be by product.
Q. Do you have an understanding as to which product was at 130 and which would be at 140?
A. Traditional would be at 140 and the managed care product would be at 130.
Q. Sticking with '93, was there a process of individualized negotiation with providers, or was it simply a matter of which product their network was associated with?
A. I think it was more which product they were associated with.
Q. And coming back to the present time period, where the range is 90 to 120 percent, can you tell me which fee schedules have which percentage along that range?
A. I know the northern Ohio schedule's 100 percent, and southern Ohio -- the 90 I just -- that may not be the exact number. But southern Ohio is slightly less than northern Ohio.
Q. Okay. I believe you mentioned earlier that there was one indemnity fee schedule that's in effect statewide at present.
A. Right.
Q. Do you know what the percentage is for the indemnity fee schedule?
A. 100 percent.
Q. And there's a PPO and HMO fee schedule; is that correct?
A. Correct.
Q. Let me clarify. Are there different fee schedules in different regions for those products?
A. For the managed care products?
Q. Uh-huh.
A. Yes. You have northern Ohio, Cincinnati and Dayton.

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Q. And do you know what the fee schedules are for those regions?
A. As a percent of Medicare?
Q. Right.
A. For the drug piece?
Q. Yeah.
A. Northern Ohio is 100 percent because it's the same as traditional. Southern Ohio, it's something a little less than 100 percent, but I don't know the exact percent number.
Q. And that covers both Dayton and Cincinnati?
A. Yes. Let me -- just to be sure, Cincinnati and Dayton, they are two separate schedules, but their drug fees are the same.
Q. There's variation in other components of the schedule?
A. There's variations in things like surgeries, codes or office visit fees.
Q. Okay. Now, given that range of 90 to -- I'm sorry. At present, was it 90 to

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120 percent, did you say, of the Medicare fee schedule?
A. Yes. But I'm talking Midwest.
Q. Right.
A. So Kentucky and Indiana are paying more than Ohio.
Q. Do you know what's being paid in relation to drugs administered in office in those states?
A. Actually, Kentucky is actually at 100 percent of Medicare. Indiana is the one that's at 120. Again, just to clarify, those are round numbers. An individual drug may vary from that. An individual procedure code -- on the professional side, you don't actually pay by the name of the drug. You pay by the HCPCS procedure code. So an individual fee for code may vary, but in general, those percents they gave are just overall average.
Q. Now, on that point, the HCPCS or CPT codes, there are some codes that apply to

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services provided by physicians, correct?
A. (Indicates affirmatively.)
Q. A type of surgery or type of procedure, right?
A. Correct.
Q. There are other codes that apply specifically to drugs, right?
A. Correct.
Q. Do you have an understanding as to whether or not those pertain to specific drugs or just types of drugs?
A. Well, I think they -- specific drugs, but not -- the HCPCS code, which are usually J codes, if you're familiar.
Q. Uh-huh.
A. It could be a blend of four or five manufacturers who are all making that same drug. So I think it's a blend of both generic and brand. Different manufacturers, but just generally the same drug.
Q. Okay. Now, based on the fact that there are a number of payments that Anthem

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makes in the Midwest in relation to drugs administered in office that are at greater than 100 percent of the Medicare fee schedule, right?
A. Yes.
Q. Do you have an understanding as to why in those cases Anthem pays its providers more than Medicare in relation to drugs administered in office?
A. The marketplace.
Q. And by "the marketplace," do you mean the demands of physicians?
A. Correct. Well, that and the competitiveness of the market.
Q. What sort of competitive factors are in play in the market that lead to that result?
A. I'm not sure if I -- can you give me an example of what you mean?
Q. Sure. Let me try and clarify. Anthem competes with other health insurers, correct?

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A. Correct.
Q. Who are some of the major competitors that Anthem faces in the Ohio market?
A. United, Aetna, Humana, Medical Mutual.
Q. And there are similar competitors in Indiana or Kentucky, correct?
A. Yes.
Q. Anthem is looking to maintain a network of providers that will provide a certain level of service to its individual insureds, correct?
A. Correct.
Q. Anthem wants to have an efficient and relatively wide-spread network, right?
A. Correct.
Q. In order to maintain that provider network, does Anthem need to offer reimbursement rates that are sensitive to the market's demands?
A. Yes.

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Q. So when we're referring to market dynamics and competitive dynamics, what we're really talking about is Anthem's need to maintain an adequate provider network, correct?
A. Correct.
Q. Now, does Anthem at present have an understanding of what physicians pay to acquire drugs?
A. I don't -- I'm not aware of that.
Q. Are there others at Anthem who would know more about that topic?
MR. THOMAS: Object.
A. I'm sorry. I don't know.
Q. Now, earlier today we spoke about WAC or direct price. Do you recall that discussion?
A. Yes.
Q. And you testified that you understood WAC to be something close to what is actually paid for drugs; is that correct?
A. Correct.

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Q. So would it be fair to say that you understand physicians pay something at or close to WAC to acquire drugs?
MR. THOMAS: Objection. I think he testified he's not aware. But go ahead and answer if you can.
A. Okay. Can you restate that?
Q. Yeah. Earlier you talked about WAC as being something close to what's paid to acquire drugs. Do you recall that?
A. Correct.
Q. Do you have an understanding as to whether or not physicians pay WAC to acquire drugs or whether they pay something less than that?
A. My understanding is that they pay something less than average wholesale price.
Q. Okay.
A. But exactly what they would pay I don't know.
Q. Okay. Do you understand that they don't pay AWP?

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A. In general, I think that they pay something less than AWP. There may be cases where they have to pay AWP. I'm not sure.
Q. Do you know of any specific cases of physicians paying AWP?
A. No.
Q. Your general impression is that they pay less than AWP?
A. Yes.
MR. MANGI: Perhaps we can take a quick break.
(Recess taken.)
BY MR. MANGI:
Q. Now, before we took that break, we were talking about physicians -- what physicians pay to acquire drugs. Now, do you have an understanding as to whether or not the amounts that physicians pay to acquire drugs are greater or lesser than the amount that Anthem reimburses them for those drugs?
MR. THOMAS: Object. I think he

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testified he does not know for certain, but go ahead.
A. I don't know for certain. I will say this, I think that what we pay them is a fair and reasonable rate, which is our goal. We're not trying to underpay them, certainly.
Q. What do you mean by "a fair and reasonable rate"?
A. Just what it says, that we think it's fair and reasonable, adequate.
Q. Okay. Is one part of fair and reasonable that Anthem is not paying providers -- is not reimbursing providers an amount in relation to drugs that's less than what they pay to acquire those drugs?
MR. MATT: I'm sorry. Can I have that question back.
(Record read as requested.)
MR. MATT: Object to form.
MR. THOMAS: I'm going to object to foundation, because, again, I believe he

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already testified he's not certain what physicians pay to acquire drugs.
MR. MANGI: I'm trying to --
A. Well, the way we would look at it, there's more than just -- I don't want to look at just one drug. You have to look at the entire fee schedule. I mean, they get paid for the drugs, but you also get paid for office visits, you get paid for administering drugs. So I don't know.
It could be that on one drug maybe our reimbursement is less than it actually costs them, but that's one drug. We're paying them much more on other things. So I'd rather look at the total reimbursement rather than one drug.
Q. Okay. Let's leave aside specific drugs and just talk about drugs generally. To pay a fair and reasonable rate, would Anthem understand that to mean that it's generally paying -- not causing providers to make a loss on drugs that they buy and then

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administer?
A. I think that's a fair statement, yes.
Q. Okay. So we can agree, then, that Anthem understands that it's reimbursing providers in relation to drugs they administer at some amount greater than what they pay to acquire those drugs?
MR. THOMAS: I'm going to interpose an objection here only because we moved from what Joe Spahn believes to what Anthem believes on a corporation basis, and I don't think we can make that jump, based upon his testimony. Foundation objection.
Q. Okay. Let's back up for a moment. You understand that you're testifying here today as a corporate representative on behalf of Anthem, correct?
A. Yes.
Q. Okay.
MR. THOMAS: That's correct. But I believe his response to the prior question

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was I believe we try to pay. I could be wrong on my recollection, but that's the basis for my objection.
MR. MANGI: That's fine.
Could you repeat my prior question, please. And we can incorporate the same objection.
(Record read as requested.)
A. Okay. I'm sorry?
Q. Let's do it again.
A. Okay. Let's do it again.
Q. Did you understand that question?
A. No. Can we do it again, please?
Q. Sure. We were speaking about fair and reasonable, right?
A. Yes.
Q. And we agreed that, as a general matter, in relation to drugs administered in office, that means that Anthem doesn't expect that the providers are making a loss on those drugs, correct?
A. Correct.

Q. Okay. So we can agree that Anthem understands that the amounts that it's reimbursing providers in relation to drugs they administer in office is something greater than what they pay to acquire those drugs?

MR. MATT: Objection.

MR. THOMAS: Same objection.

A. The only issue I have with that is I don't know what they actually pay for the drug. So it's difficult to answer. But I would assume that we're paying an adequate rate because they stay in the network to not cancel their contract.

Q. By "an adequate rate," you mean a rate that doesn't cause them to make a loss on the drugs, correct?

MR. THOMAS: I'm just going to object to the whole line of testimony.

A. Well, I --

MR. THOMAS: Wait, Joe. Wait till I'm done with my objection.

I object to this line of testimony on the grounds that it's pure speculation. Go ahead.

A. You guys crack me up. Now I lost my train of thought.

Q. Would you like the question read back?

A. Yes, please.

Q. And we can incorporate the same objection.

(Record read as requested.)

A. By "an adequate rate," I mean it's a rate that causes them to continue to participate with Anthem as a contracted provider.

Q. Okay. Would it be fair to say that Anthem, when contracting with providers, is looking to get the best deal that it can, the best financial terms that it can, while ensuring that it maintains an adequate network?

A. We want to pay a rate that is --

that is fair, reasonable and equitable to the provider, while at the same time controlling cost of care.

Q. And maintaining an adequate network?

A. And maintaining an adequate network, yes.

Q. Okay. Those goals that you described, were those the same goals that Anthem had in mind prior to 1993?

A. I'm not sure if I can answer that.

Q. Okay. Well, leaving aside, obviously, the network component, because we're talking about a premanaged care time, is it fair to say that, even prior to 1993, when reimbursement was based on actual bill charges, Anthem, or in that pre-'93 world Community Mutual, was looking to pay providers a fair and reasonable rate in reimbursement?

A. The reason I'm having a hard time answering that, because I wasn't in health care management at that time, so I'm not

sure what they were thinking.

Q. So you have no understanding of what was happening in that time period?

A. No, I don't.

Q. Let's stick with the present time period, then. Now, I believe the goals you mentioned that Anthem has when contracting these rates is, one, to pay a fair and reasonable rate, right?

A. Correct.

Q. And, second, to maintain an adequate network?

A. Correct.

Q. Was there a third?

A. I think -- I believe I said controlling cost of care.

Q. There you go.

Now, those three goals, would it be fair to say that those are Anthem's goals regardless of the particular reimbursement methodology that it utilizes?

A. Yes.

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Q. So, indeed, if Anthem were to use a reimbursement methodology other than percentage of Medicare, those would remain Anthem's goals, right?
A. Correct.
Q. If, for example, Anthem were to change from a percentage of Medicare to a percentage of AWP, a percentage of WAC, or a percentage of something else, those would remain Anthem's aims, right?
A. Yes.
Q. Now, we've been talking so far about reimbursement to providers or physicians for drugs administered in office. Are you also involved in reimbursement to hospitals?
A. No.
Q. Do you have an understanding of how Anthem determines its reimbursement rates to hospitals?
A. No, I don't.
Q. Do you have any knowledge as to how Anthem reimburses hospitals for drugs

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administered to patients?
A. No, I don't.
Q. Do you have any understanding as to whether the amount reimbursed for drugs is broken out from general per diem or capitated reimbursement or whether it's just part of a broader reimbursement?
A. I'm sorry. I don't know.
Q. Your involvement is limited to physician reimbursement?
A. Correct.
Q. Does Anthem utilize the services of any benefits consultants?
A. I don't know.
Q. Are you familiar with benefits consultants? Do you know what those are?
A. No, I don't.
Q. Okay. Does Anthem utilize the services of any consultants in relation to determining its reimbursement rates or methodologies?
A. For physician reimbursement?

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Q. For physician reimbursement.
A. No.
Q. Now, leaving aside physician reimbursement and talking about reimbursement related to pills or other pharmacy-dispensed medications, is it your understanding that that reimbursement is all determined through Anthem Prescription Management?
A. If we're talking about prescription drugs --
Q. Right.
A. -- I would say yes, I think it is.
Q. Do you have any responsibility in relation to reimbursement for those drugs?
A. No.
Q. Now, do you have an understanding of what average wholesale price stands for or what that acronym is? I'm sorry. Withdraw that question.
Do you have an understanding of what average wholesale price is?

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A. My understanding is that when a drug comes on the market -- my understanding is that AWP, average wholesale price, is set by the manufacturer. I believe it's originally set when the drug is FDA approved. And apparently they -- the manufacturer can change that AWP through time.
Q. What's the basis for your understanding that AWP is set by manufacturers?
A. Just from what I've heard, even in our fee schedule meetings, what other people have said.
Q. Are you aware that some price reporters publish AWPs for drugs that are different from those they receive from drug manufacturers?
A. No.
Q. Do you have an understanding as to what, if anything, AWP is used for in the marketplace or in the health care industry?
A. I think I'm going to say no.

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Q. Okay. Do you know whether or not other insurers tie their reimbursement in relation to drugs to a percentage of AWP?
A. I wouldn't know.
Q. Do you know whether or not the amount that Anthem reimburses pharmacies in relation to drugs dispensed at pharmacies is or is not tied to AWP?
A. I don't know.
Q. Do you have any knowledge as to whether or not AWP is used as a reimbursement benchmark?
A. For prescription drugs?
Q. For drugs in general.
A. I don't know.
Q. Have you ever heard AWP referred to as "ain't what's paid"?
A. I think I have heard that, yes.
Q. What do you understand that to mean?
A. My understanding is that's -- my understanding of what that would mean is that's not what the physician pays to

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acquire the drug, even from a wholesaler or from the manufacturer.
Q. Now, in relation to reimbursement to providers, does Anthem Prescription Management play any role in that reimbursement process?
A. Well, "providers," you mean physicians?
Q. Yes.
A. So do they have any role in setting the physician fee schedule?
Q. In setting or in any other aspect of that reimbursement.
A. No.
Q. How about in the processing of claims from physicians?
A. No.
Q. Okay. How are those claims from physicians processed?
A. Well, I don't work in the claims area, so I don't know for sure, but a professional claim is called a HCFA 1500

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Form. I mean, I've seen them. You have the J code, the HIPAA code. And exactly what the claim shop -- how they process them, I don't know.
Q. But it's your understanding that those claims are processed at Anthem by a department other than Anthem Prescription Management; is that correct?
A. Yes.
Q. Now, do you have an understanding as to what criteria Anthem uses when deciding whether or not to contract with a provider?
A. No, I don't.
Q. Who at Anthem is the person most knowledgeable about that process, the contracting process with providers?
A. Gosh. I don't know if I can name one person.
Q. Okay. Could you name more than one?
MR. THOMAS: I think you asked for the most knowledgeable person, so I'm going to object to the follow-up on a form basis.

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Q. I'm happy to clarify.
Would you feel more comfortable naming more than one person who's knowledgeable about that process?
A. Well, I'm not real comfortable naming any person.
THE WITNESS: Can I answer?
MR. THOMAS: You can answer the question.
A. In central contact, there's Jim Tassing. But the people who actually negotiate with the physicians, if that's the question you're asking, that would be provider relations.
MR. THOMAS: You can name them.
A. The VP of provider relations for southern Ohio is Paul Beckman. The VP in northern Ohio is John Jesser.
Q. Could you spell his last name.
A. J-e-s-s-e-r.
Do you also want Kentucky and Indiana?

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Q. Sure.
A. Kentucky is Mike Lorch.
Q. Is that O-r-c-h?
A. L-o-r-c-h.
And Indiana is David Lee, L-e-e.
Q. And these --
A. So those folks and their staffs are the ones who would actually negotiate with the physicians.
Q. Those are provider relations?
A. Correct.
Q. Now, the reimbursement amounts that are paid to physicians in relation to drugs administered in the office, do you know whether or not those amounts vary depending on the physician's area of practice or specialization?
A. No.
Q. Is the answer they do not vary?
A. They do not vary by provider specialty.
Q. Okay. So the only variation stems

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from the type of plan; is that correct?
A. The geographic region and the type of plan.
Q. Okay. Now, let's go back and try and clarify a particular point.
You mentioned earlier that you understood the Medicare fee schedule to be based on percentages of AWP to date.
A. Correct.
Q. So you understand that if we took a particular drug, that Medicare reimbursed first at 100 percent of the AWP for that drug, and then at 95, and then at 85; is that correct?
A. Correct.
Q. So it's your understanding there that Medicare was reimbursing by reference to the average wholesale price for a particular drug; is that correct?
A. Yes.
Q. Now, turning to Anthem's reimbursement, which is based on a

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percentage of Medicare's reimbursement, is Anthem's reimbursement then also based on a percentage of the AWP for a drug with the Medicare fee schedule acting as an intermediary? Can you answer my question?
A. Well, when we're setting the fees, AWP doesn't come up. Because what physicians talk about is -- their benchmark is what Medicare pays and what you pay me as related to Medicare.
Q. Here's what I'm trying to understand. Earlier on, you referenced the fact that reimbursement is tied to J codes.
A. Correct.
Q. Anthem's reimbursement.
A. Correct.
Q. And a J code can include more than one drug, right?
A. A J code can include more than one manufacturer of a drug.
Q. Okay.
A. Right. It could have generic and

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brands mixed together. So there could be multiple NDC numbers in one J code.
Q. Is it your understanding that a J code can include more than one branded drug?
A. I don't know.
Q. Now, changing focus slightly from the amounts that Anthem reimburses for drugs that are administered in office, I'd like to talk now about the amount that Anthem reimburses providers for the administration fees associated with administering those drugs to patients.
A. Okay.
Q. Does Anthem reimburse a separate amount to physicians in relation to the administration fee for infused or injected drugs?
A. Are you asking, did we pay separately for administration as opposed to the drug?
Q. Right.
A. Yes.

Q. How does Anthem calculate the amounts that it will pay in relation to that administration?
A. Our fees for administration are based off our RBRVS.
Q. Is it your understanding that the amounts that Anthem reimburses in relation to administration -- providers of administration fees are also tied to the amount that Medicare reimburses?
A. You could calculate it, but when you're setting the fees, you don't really set the fees saying we want to pay 110 percent of Medicare. The fees are set saying we want to use a conversion factor of $40 or $45, whatever it is.
Q. Okay. Has Anthem ever studied the practice expenses of providers?
A. I'm not aware of that.
Q. Has Anthem ever analyzed the overhead expenses associated with running a physician's practice?

A. Not that I am aware.
Q. Does Anthem have an understanding as to whether or not the amounts that it reimburses providers in relation to administrative fees alone, leaving aside the reimbursement for the drug itself, are sufficient to cover the provider's overhead expenses or practice expenses?
A. I'm sorry. Could you say that again, please.
MR. MANGI: Sure. Would you mind reading back the question, please.
(Record read as requested.)
MR. THOMAS: In your "sufficient to cover the overhead," you're referring to the overhead and cost to administer the specific drug?
MR. MANGI: Right.
MR. THOMAS: Okay.
A. I don't know, because I don't know what their physician's overhead expenses are.

BY MR. MANGI:
Q. Okay. To the best of your knowledge, Anthem has never analyzed those expenses?
A. As far as I know, they never analyzed those expenses.
Q. So to the best of your knowledge, Anthem doesn't know whether the administration fees that it pays are sufficient to cover those expenses, right?
A. Yes. Correct.
Q. Do you know whether or not the administration fees are subject to negotiation?
A. No. I mean, when you -- when we're setting our schedules, no, they're not subject to negotiation.
Q. Okay. Has Anthem made -- well, the use of RBRVS in relation to calculating those administration fees, how long has that methodology been in place?
A. Since 1993.

Q. And prior to that time, Anthem was paying a percentage of the physician bill charge, correct?
A. Correct.
Q. Was it a percentage of the bill charge or the actual bill charge prior to 1993?
A. For physician services, other than drugs, for services like surgeries and administration, et cetera, you pay what's called UCR. You would pay at a percentile. So you'd pay the 90th percentile or 80th percentile.
Q. What about in relation to drugs? In determining the amount that Anthem would reimburse prior to '93 for drugs administered in office, was it reimbursing the bill charge from the physician or percentage of the bill charge?
A. No. It was paying a percentage of the bill charge.
Q. Do you know what that percentage

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was?
A. No, I don't.
Q. Now, we spoke earlier about the competitive dynamic in the market. Are there particular physicians' practices that are able to individually negotiate their reimbursement rates in relation to drugs and other expenses?
A. Yes.
Q. Okay. On what basis can individual practices negotiate their own deals?
A. On what basis can they negotiate their own deals?
Q. Yeah. Do you understand the question or shall I clarify?
A. I think so.
Q. Okay. Are there circumstances in which one practice or practice group would have greater bargaining power than another?
A. If you have what I would -- if you have, like, a multi-specialty clinic that's out in a rural area, there's no other

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providers available to negotiate with, then I would say they would have more bargaining power.
Q. So in that instance, that practice would be a must-have for Anthem to have an adequate network; is that a fair statement?
A. It might be a must-have. It kind of depends on how many accounts we have in that area. If General Motors builds a plant right next to that multi-specialty clinic out in the rural area, they're probably going to be a must-have provider.
Q. Okay. So the idea is that if there's a practice, a multi-specialty practice in an area where there are not a lot of other options, and Anthem has individual insureds in that area, then it will need that practice to have an adequate network?
A. Correct.
Q. In that situation, that practice would have -- would be in a much stronger

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bargaining position than an individual physician in Cincinnati?
A. Correct.
Q. Now, in that situation, that physician's practice would be able to negotiate to receive a greater amount in reimbursement for drugs that it administers in office?
MR. THOMAS: I'm going to object on the grounds this calls for speculation. You're dealing with a hypothetical practice in a hypothetical environment dealing with hypothetical negotiating physicians. And I'm going to caution the witness not to speculate. Go ahead.
Q. Would you like the question read back?
A. No.
Q. Okay.
A. Let me take a stab at answering it. I can tell you what our system -- our claims system has the capability -- we have a

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standard fee schedule. We have the capability of paying -- we can flex -- it's called flex the provider. So you can pay provider A 110 percent of the standard schedule. So the system has the ability to do that.
Q. Okay. So the system has the ability to adjust the percentage of the fee schedule that we pay to a particular practice?
A. Correct.
Q. Okay. And that's called flexing the practice, is it?
A. Correct.
Q. Okay. So you are aware of instances where a particular practice is flexed, so to speak, or is paid a higher percentage of a fee schedule?
A. Yes.
Q. And is it your understanding that that takes place in cases where that practice group has negotiated a higher reimbursement rate?

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A. I'm sorry. Can you say that again?
Q. Sure. Is it your understanding that that takes place in instances where the practice group at issue has negotiated a higher reimbursement rate?
A. Yes.
Q. Based on factors similar to those that we have been discussing?
A. Yes.
Q. Other than being a major practice in an underserved area, are there other competitive factors that would give one practice greater bargaining power over another?
A. You might have a situation like physicians who work at a children's hospital, and they're doing services on pediatric -- you know, children that no one else does. So they have more bargaining power.
Q. Any other instances?
MR. THOMAS: I'm just going to

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object to the extent that he's already testified that he's not involved in provider contracting, so you're not getting -- you're getting Joe's opinion on this.
Q. Well, you did testify earlier that you're knowledgeable about some aspects of provider contracting, correct.
A. Yes.
Q. Okay. Would you like the question read back?
A. I'm sorry. I thought I answered the question.
Q. Oh, did you? Perhaps I got confused by the objection this time.
MR. THOMAS: He answered the first one, and then you asked a follow-up question.
MR. MANGI: Would you mind re-reading the follow-up, please.
(Record read as requested.)
BY MR. MANGI:
Q. We spoke about a multi-specialty

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practice in an underserved area and about a children's hospital instance that you just mentioned. Other than those sorts of cases, are there other circumstances you know of where one provider or practice would be in a stronger bargaining position than another?
A. No. I think those are the main ones.
Q. Okay. Now, I believe you mentioned earlier that conversations with providers about reimbursement tend -- they tend to talk in terms of the Medicare rate. Do I recall that correctly?
A. Well, my understanding from the meetings I've had with provider relations folks, it seems to be that physicians talk in terms of Medicare's the benchmark and, you know, they tend to compare what everyone pays to what Medicare pays.
Q. Do you have an understanding as to the position that physicians generally take in relation to Medicare reimbursement? Do

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they insist on an amount greater than it, for example, or something else?
A. It actually varies. It depends.
Q. What are some of the variations that you're aware of?
A. It could depend on -- I'm not sure if I -- some of the variations? Can you --
Q. Would you like a clarification?
A. Yes.
Q. Are you aware of different positions that different providers and practices have taken in relation to what their reimbursement should be by reference to the Medicare reimbursement amount?
A. No, I don't think so.
Q. Okay. Do providers -- do you know whether or not providers insist on the Medicare amount as a baseline amount?
A. Again, going from feedback that I'm getting when I'm in these meetings, I would say that they usually would want -- in general, it seems like that's kind of the

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baseline.
Q. Okay. And since that's the baseline, is it fair to say that, as a general proposition, providers are seeking reimbursement at an amount greater than the Medicare fee schedule?
A. In general, yes. But there's another component, too, which is volume. You have to -- you know, if Anthem is -- drives a lot of volume to that provider, you know, they may be willing to -- because, you know, what they're looking at is their total reimbursement. You got the -- how much you're paying them for each procedure, but also the number of procedures that they do.
So if Anthem has a large membership in an area, they may be willing to take less than the actual fees, but they make more money because of the volume.
Q. So the determination of the reimbursement rate that will be paid to a practice is very much an individualized

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issue focusing on that particular practice, correct?
A. Did you say an individual practice?
Q. Let me clarify the question.
We've discussed how there are some competitive factors that give one practice a stronger bargaining practice than another, right?
A. Correct.
Q. And what we just discussed is that volume would also be a factor in determining the reimbursement rates, how much volume Anthem drives towards a particular physician practice?
A. Correct.
Q. So it's fair to say that the determination of the amount that Anthem will reimburse a practice for drugs that are administered in office turns on factors specific to that practice, right?
A. Correct.
Q. Including its competitive bargaining

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power, the amount of volume that's driven to it by Anthem?
A. Correct.
Q. Are there other factors that go into that calculation?
A. I think those are the main ones.
Q. Okay. Now, do you have an understanding -- well, withdraw that.
You know that there are some drugs that can be administered either in a physician's office or in a hospital, correct?
A. I assume there are. Again, I'm only familiar with the physician side.
Q. Okay. Do you have an understanding as to whether Anthem regards the administration of drugs in physicians' offices as being more or less cost-effective than the administration of the same drug in a hospital setting?
A. I don't know. I've never heard anyone talk about that.

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Q. Okay. Are you aware of any analysis at Anthem regarding the relative costs of administration of a drug in a physician's office versus a hospital setting?
A. No, I haven't.
Q. Now, you testified earlier that Anthem has -- does not know exactly what providers are paying to acquire drugs, correct?
A. Correct.
Q. That's not something that -- withdraw that.
Anthem does not require providers to disclose their acquisition costs for drugs as part of their contracts with those providers, correct?
A. Correct.
Q. So providers' acquisition costs for drugs do not form part of Anthem's determination of what it will reimburse them in relation to drugs?
A. Correct.

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Q. The reimbursement is driven entirely by the fee schedule?
A. Correct.
Q. Regardless of what the specific provider's acquisition costs for those drugs may be?
A. Correct.
Q. So if, for example, Anthem were to learn that a particular provider were getting a discount or a rebate on a particular drug that lowered his acquisition costs for that drug, that wouldn't change the amount that Anthem is reimbursing that practice in relation to that drug, right?
A. No.
Q. Because the reimbursement amount is tied to the fee schedule?
A. Right.
Q. And if Anthem were to learn that providers in a region were getting a discount or rebate from a drug manufacturer in relation to a particular drug, again,

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that wouldn't change the amount Anthem reimburses because that's tied to the fee schedule?
MR. THOMAS: Asked and answered.
A. Yes. That's correct.
Q. Do you know whether Anthem's contracts with providers contain confidentiality clauses?
A. I don't know.
Q. Do you know whether or not -- are you aware of any free sample programs whereby providers can get free samples of drugs from manufacturers?
A. No, I'm not aware.
Q. That's not an area that you deal with?
A. No.
Q. Are you familiar with the major drug wholesalers operating the market today?
A. No.
Q. Do you have an understanding of what wholesalers pay to acquire drugs?

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A. No, I don't.
Q. Are you familiar with prompt pay discounts?
A. No, I'm not.
Q. You've never heard that term?
A. No, I haven't.
Q. To the best of your knowledge, do you know of any instances where providers have conspired with drug manufacturers to inflate the average wholesale prices for drugs?
A. No.
Q. Are you aware of any instances where pharmacies or pharmacy benefits managers have conspired with any drug manufacturers to inflate any drug's average wholesale prices?
A. No.
MR. MATT: Objection. No foundation.
MR. THOMAS: I was just going to let it go.

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Q. Do you know whether Anthem has been involved in any litigations pertaining to average wholesale prices for drugs other than this one here today?
A. No.
MR. THOMAS: Objection. Foundation.
Q. Do you know of any other litigations that Anthem has been involved in relating to reimbursements to providers for drugs administered in office?
A. No.
MR. THOMAS: Same objection.
MR. MANGI: Let's take another quick break and then we'll look at some documents.
(Recess taken.)
BY MR. MANGI:
Q. Prior to the break, we were talking about providers' acquisition costs and the fact they're not relevant to Anthem's reimbursement amounts. Do you recall that testimony?
A. Yes.

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Q. Okay. And part of that was that Anthem has no information about what the providers' acquisition costs are, right?
A. Correct.
Q. So it's fair to say that Anthem has no particular expectation that providers' costs would be, you know, 10 percent, 30 percent, 50 percent, something more, something less than the amount they're reimbursed in relation to those drugs, right?
MR. THOMAS: Object to form.
A. Yes.
Q. I'd like to just plug a couple of gaps here.
Do you know how many states Anthem operates in nationwide?
A. Gosh. I think it's nine.
Q. Do you know how many regions that's divided into? One is the Midwest that we've been discussing.
A. You have Mideast, you have Midwest,

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you have West, and you have South, Southeast. I think Virginia's called the Southeastern region.
MR. THOMAS: It's just East. It's not Mideast.
A. Did I say Mideast? Sorry. East, West, Midwest and Southeast.
Q. So a total of four regions?
A. Four regions.
Q. Do you have an understanding as to whether or not Anthem reimburses providers that are not part of its network if an individual insured is treated by that physician?
A. I'm sorry. Could you repeat that?
Q. Sure. You understand that Anthem has contracts with providers, correct?
A. Correct.
Q. And you understand that Anthem's insureds primarily are treated by those providers?
A. Correct.

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Q. Now, if an Anthem insured visits a doctor that is not part of Anthem's network and is administered a drug by that doctor, do you have an understanding as to whether or not Anthem will reimburse that doctor in relation to that drug?
A. Do I have an understanding?
Q. Right.
A. Yes.
Q. What are the terms of that reimbursement?
A. Well, we wouldn't. If they're non-par, we wouldn't reimburse.
Q. I'm sorry?
A. If they're not par, non-participating, if they're noncontracted, then we don't -- we wouldn't reimburse them. We'd reimburse the member.
Q. So in that instance, the individual member would pay the physician's full bill and then seek reimbursement from Anthem?
MR. THOMAS: I'm going to object on

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foundation. We're not talking about any specific product here. It may vary depending upon product.
Q. Sure. Let's clarify that.
Do you have an understanding as to whether reimbursement for out-of-network-provider visits varies from plan to plan or product to product?
A. No. It's the same.
Q. Okay. Now, in those instances, will Anthem reimburse anyone in relation to that office visit?
A. We would repay our fee schedule amount to the member.
Q. So the responsibility for making payments to the physician would rest entirely on the member; is that correct?
A. Correct.
Q. And the member would then seek reimbursement from Anthem?
A. Correct.
Q. And in that instance, when we're

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talking about a drug that was administered to the patient specifically, Anthem would reimburse the individual by reference to its fee schedule?
A. Correct.
Q. So from an individual insured's perspective, is the only difference in visiting an in-network physician versus an out-of-network physician whether or not they pay out of pocket and are reimbursed or whether they only make a co-pay?
A. I don't know the benefits. Co-pays and deduct amounts may be different. I don't know.
Q. But in relation of reimbursement for the drug, the amount Anthem pays is the same, the only difference is who it pays it to, correct?
A. Yes, that's correct.
Q. For an out-of-network visit, it will pay the member; for an in-network visit, it will pay the physician?

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A. Correct.
Q. Now, the current methodology, which is percentage of the Medicare amount, does Anthem currently have plans to change that methodology?
A. I don't know, because that would be at the next fee schedule meetings that would be discussed. I'm not aware of any plans to change it.
Q. How often are fee schedule meetings held?
A. Annually.
Q. Who attends the fee schedule meetings?
A. In the Midwest, there are four health service areas, which we talked about before, northern Ohio, southern Ohio, Kentucky, Indiana. Each one of those four has a team, a reimbursement team. So that's the group that meets.
Q. Are you part of the reimbursement team?

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A. Yes.
Q. For which region, or for all of them?
A. Actually, for all of them.
Q. And what sorts of issues are discussed at these annual meetings?
A. In general, we look at our current schedule, and then decide if we need to make any changes to it, either increases or decreases.
Q. Okay. Have there been both increases and decreases made over time?
A. Yes.

-=0=-

(Exhibit Spahn 001 marked.)

-=0=-

Q. Let's turn now to a document that's been marked as Exhibit Spahn 001. Could you take a moment to review that, and let me know when you're done, please. I realize it's lengthy.
MR. THOMAS: Please look at each

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page before you tell him you're ready.
Q. Okay?
A. Yes.
Q. Now, the sender of this e-mail is Amber Hoevener; is that correct?
A. Yes, I believe so.
Q. Am I pronouncing her name correctly?
A. I think so.
Q. Do you know who Mrs. Hoevener is?
A. I know she works for Paul Beckman.
Q. And could you remind me who Mr. Beckman is?
A. He's vice president of the southern Ohio health service area.
Q. You're one with of the recipients of this e-mail, correct?
A. Yes.
Q. And the subject is 5/30/4 PDRT Meeting Minutes?
A. Yes.
Q. What does PDRT mean to you?
A. I believe that's professional drug

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reimbursement team.
Q. Are these the same meetings that we were just speaking about before looking at this document?
A. No.
Q. What are these professional drug reimbursement teams?
A. I may not be the best person to ask this. Paul actually heads up the team.
MR. THOMAS: To the extent you know, you can answer. If you don't know, you can tell him you don't know.
A. Quite frankly, I'm a little confused as to what goes here. It seems like they're talking about what they refer to as specialty drugs, and I frankly am not clear as to what is meant by specialty drugs.
Q. Are you part of the professional drug reimbursement team?
A. I don't know formally if I am or not. I'm often invited or copied on stuff because I work with the fee schedules.

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Q. Okay. Do you have a recollection of this e-mail, of receiving this e-mail?
A. Boy, I don't -- this was back in, what, May. I did not remember until I saw it here.
Q. Okay.
MR. MANGI: Can I ask counsel to clarify whether the redaction is for privilege or for some other reason?
MR. THOMAS: You can ask, but I won't be able to respond. That was done by counsel in Virginia. I responded with all the documents and forwarded them to Virginia.
Q. I'd like you to turn to the horizontally-oriented page. Under Recommendations/Actions, the first entry is, "Develop a Midwest chemotherapy admin fee recommendation and time line."
And you're responsible as one of the persons for follow-up. Do you see that?
A. Yes.

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Q. Do you recall what this project involved?
A. In simple terms, it was if we change our -- if we change our drug fee reimbursement, what we want to do with our chemotherapy administration fee reimbursement.
Q. So the discussion was that if -- by drug fee reimbursement, you mean administration fees associated with the administration, injection of drugs in physicians' offices?
A. Well, drug fees, I mean the fee for the drug itself.
Q. Okay. So the discussion here was what to do with the fee schedule in relation to administration expenses if the amount in relation to drugs were changed?
A. Correct.
Q. Okay. What was the background to this in terms of changing the drug component of the fee schedule?

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A. Because we were aware that Medicare was going to ASP plus 6, which seemed to be a reduction. So if we stayed with our current 100 percent of Medicare, that means our drug fees were going to go down. So the question was, if that happens, do we want to do anything at all with our administration fees. Example, would we want to leave them the same, or do we want to maybe increase them to offset part of the decrease in the drug fee.
Q. So Anthem recognizes that the administration fees and the reimbursement for the drug are two related components that go together to make up the physician reimbursement, correct?
A. Correct.
Q. And if the amount reimbursed for the drug were to fall, Anthem could raise the amount reimbursed for administration and arrive at a roughly parallel number?
A. Correct.

Q. And indeed, similarly, taking the vice versa angle, if administration fees for drugs were somehow insufficient to cover providers' expenses, a higher reimbursement in relation to the drug could act as a subsidy?

MR. MATT: Object to the form.

A. Yes. That's correct.

Q. Now, the discussion here related only to the Medicare change to an ASP basis, then; is that correct?

Let me rephrase the question more clearly. Were there any changes to the amount of reimbursement in relation to drugs that were under discussion here other than the fact that Medicare was moving to an ASP plus six system?

A. Well, I don't remember exactly, but from my point, my involvement was, you know, if Anthem decides to change their drug fees for whatever reason -- and the big drive at that point was, since we peg it to Medicare,

if Medicare goes down, our drug fees go down, the total reimbursement to, say, like oncologists who are big users of drugs, is going to be affected.

So is that okay or do we need to possibly increase the administration fees to offset part of the total reduction reimbursement that the oncologists would see.

And the other part was time line. Do you want to do it at the same time? Do you want to maybe -- if the drug fees would be reduced, do you want to do something -- either increase or leave the same your administration fees at the same time, or do it at a different time.

Q. Is there a reason why the discussion here focused on chemotherapy administration fees as opposed to physician administration fees generally?

A. Well, in my mind, it's almost the same. It's almost the same thing. The only

real administration fees you have for drugs are the chemo administration fees. There are some administration fees for injections, but that's really a small piece. This is the -- this is by far the biggest piece of reimbursement, the chemo administration fees.

Q. Are you aware of the fact that there are non-chemo drugs that are administered in physicians' offices?

A. Yes.

Q. And you're aware that some of those are infusion drugs?

A. Yes.

Q. So is the reason that this project was focused on chemotherapy simply because that's a large component of the physician-administered drug market, or were there other reasons also?

A. Well, this might be a slight misnomer here. They're saying chemotherapy administration fee. It's any drug that's

infused, whether it's technically considered chemo or not. They can still bill this administration fee.

Q. So the intention here was to refer to all the admin fees and not just admin fees for chemo drugs?

A. Yes, that's correct.

Q. Okay. Did you indeed carry out this project?

A. Carry it out, meaning that the recommendation was made?

Q. Right.

A. Well, the final decision is always going to be made by those four reimbursement teams.

Q. Right. At the annual meeting?

A. At the annual meetings. And those are four separate meetings. It's not like one big meeting.

Q. I see. So the teams from the different regions don't get together for one comprehensive meeting --

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A. No.
Q. -- but each has its own meeting?
A. Correct.
Q. Did you develop a Midwest recommendation?
A. Well, yes. I mean, the recommendation was that at any time the drug fees -- if the drug fees were to be reduced -- I'm trying to say this. If any HSA decided to reduce the drug fees, that they should make an adjustment to the chemo -- to the administration fees at the same time.
Q. What is an HSA?
A. Health service area.
Q. So that's a region, one of the Anthem regions that you discussed earlier?
A. Correct. Well, it's not a region. It's within the Midwest -- the Midwest is a region with Anthem. Within the Midwest, there are four health service areas, northern Ohio, southern Ohio, Kentucky, and

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Indiana.
Q. Okay. So the recommendation that you made was that if they were to lower, or if the amounts that they reimbursed in relation to drugs were to fall, then they would need to correspondingly increase the administration fee?
A. Correct.
Q. Has that recommendation been accepted at these annual meetings yet?
A. Yes.
Q. When did those annual meetings take place?
A. Again, it varies by the HSAs. Usually -- it's not just one meeting. It's usually a series of meetings. But they usually start around mid-summer, like June or July. Then there will be several follow-up meetings.
Any time you're going to make a change to your fee schedule, you have to give physicians a 45-day notice. The

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contract says you have to give 45-day notice. So you always are working back from your time line.
So, in other words, if you want to change your fee schedule January 1st, you need to have decisions made by November, so you have adequate time to give notice.
Q. Has a time line been developed now for the implementation of that recommendation?
A. Well, again, everyone's done something slightly different. But, yes, the answer's yes.
Q. Now, looking at the second -- the box beneath the one we've been looking at underneath the recommendations and actions column. The next entry there is, "Provide additional analysis regarding the provider's profit margin for chemotherapy drugs that have gone generic."
Now, do you have an understanding as to what the background was for this

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particular project?
A. No, I don't.
Q. Is that something that you were not involved in?
A. No, I was not involved in this.
Q. We can agree that it does appear that there are others at Anthem that are analyzing providers' profit margins?
MR. THOMAS: I'm going to object to foundation and object to form. I don't think you can glean that from that statement.
MR. MANGI: Okay.
Q. Would you agree with me on that?
A. No. I mean, I have to say, I don't know. No one's ever talked to me about it.
Q. Who is Beth McCarty?
A. She's an Anthem employee. She's a pharmacist based in Indiana.
Q. How about Bob Lenza?
A. He's also a pharmacist. He's, I think, in New Hampshire.

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Q. Would you turn to the next page, please. Under the discussion column, four lines from the bottom -- from the top in the first paragraph. The sentence, "Additional data has been requested to determine provider's profit margin based on the drugs gone generic."
Do you see that?
A. Yes.
Q. Do you have any of idea what that's referring to, what data?
A. No, I don't.
Q. Would Ms. McCarty and Mr. Lenza know that?
A. I don't know.
Q. If you could turn -- do you see at the bottom of the page there are numbers -- A-OH and then a number after it?
A. Okay.
Q. Turn a couple pages and get to the page with the number ending 586. Do you got that?

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A. Okay.
Q. Do you see the entry, "Enterprise Wide Specialty Rx Strategy Meeting"?
A. Yes.
Q. Could you review the entry there under the discussion column, please.
A. All right.
Q. Now, the second sentence there says, "The team agreed Anthem needs to get to NDC Pricing."
Do you see that?
A. Yes.
Q. Do you have an understanding as to what the discussion was here and why the team felt they need to get to NDC pricing?
A. I'm not sure I'm the best one to answer that.
Q. Okay. Do you know the answer to the question?
A. It would be somewhat of an assumption on my part, if that's all right.
MR. THOMAS: Well, it's qualified

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adequately.
Q. Okay. Go ahead.
A. The NDC number gets right to the actual -- the drug, the actual manufacturer. It's much more specific than the J code. It even gets right down to the dose. Sometimes those J codes, the dose is even confusing. So I think the idea there was that if you wanted to get down to pricing the drug -- the actual individual drug per the right dose, per the right manufacturer, you had to get to the NDC level.
Q. Further down, four or five lines down, sentence starting with, "The team would also like to set a common reference pricing for the Anthem regions to follow."
A. Okay.
Q. Do you see that?
A. Yes.
Q. It says, "Each region will be identifying their first and second choice..."

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Were you involved in discussions about this issue?
A. No.
Q. Going to the next paragraph, it says, "The PDRT discussed the various options and agreed that following Medicare was the first choice, recognizing that it has Pros and Cons and AWP was the second choice. Medicare offers more data and is market friendly..."
Do you know what's meant by that, "more data and market friendly"?
A. I don't know what they mean by more data. Market friendly, my assumption is that they mean if physicians are used to where it's published. Anybody can go out to Medicare's web site and download their drug fee schedule.
Q. Then it continues, "However, it restricts Anthem's flexibility."
What do you understand by that?
A. Again, I'm pretty sure what they're

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going back to is the fact it goes by J code. One J code could have multiple NDC numbers under it. So what could happen is, you know, the fee for that J code is set -- I could give an example -- $100. But you might have a brand name drug that's under there. And if the physician uses the brand name, but he still gets to bill that J code because our system doesn't accept NDC codes, well, he's going to get paid a blended rate of brand and generic. He's not going to get paid specifically for the brand.

So, once again, if you can get to the NDC number, you can pay him or her for exactly the exact drug they get. So if they gave a brand, you can pay for a brand, as opposed to paying for like a blend of brand and generics.

Q. Then it continues, "Per Bob Lenza. AWP is the easiest way to get to the NDC level."

So moving to a reimbursement system

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based on AWP rather than Medicare would provide the advantage of getting directly to that issue?

MR. THOMAS: Foundation objection. That's what that says. You're going to ask him.

Q. Yeah. Do you agree with that statement? Do you agree with Mr. Lenza?

A. You cannot get to -- you can't get to the NDC level through Medicare's current schedule because it goes by J code. So, yes, I would agree.

Q. Then it continues, "Additional feedback will be received at the Midwest fee schedule meeting on May 11."

Do you recall that meeting? Did you attend that meeting?

A. I don't recall.

Q. Is this the annual meeting we were discussing earlier?

A. I don't think so.

Q. Do the annual meetings go by a

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particular name?

A. There's not a formal name, no. I would just say there's the northern Ohio meeting, the southern Ohio meeting, the Kentucky meeting, the Indiana meeting.

Q. Do you recall any further discussion on this topic at any meetings?

A. Just in a general way. I know it continues to be talked about, is there some way we pay drugs by the NDC code instead of by J codes.

Q. And is that discussion in relation to all drugs administered in physicians' offices?

A. Yes.

Q. Why is Anthem interested in getting to that NDC level? To put it another way, what's the advantage to Anthem of getting to that NDC level?

MR. THOMAS: Asked and answered, I believe. Go ahead.

A. Well, again, it solves the problem

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of paying for the exact drug, manufacture and dose that the provider gave. Again, to go back to that J code example, sometimes the provider will complain, but I gave a brand, and this rate you paid me is for like a blend, brand and generic. And we say, but what can we do. We pay by code. We pay by HCPCS code or J code today. If we went to NDC number, then we could pay them for the brand.

Q. So the advantage to the provider would be that they'd be paid a higher reimbursement for a branded drug that's in the same J code as generic drugs, correct?

A. Well, the advantage is that they'd be paid for the exact drug that they gave.

Q. But the reason why it's an issue for providers is because there are instances where there's a branded drug and generic drugs in the same J code and so the provider's being paid a blended rate that will be lower than the AWP for the branded

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drug, right?
A. Yes, that's correct.
Q. So it's a problem for the provider because they're being paid less under the current system than they would under an AWP reimbursement system? That's the basis for their complaints, right?
MR. MATT: Objection.
MR. THOMAS: I also object. I think you changed gears on him. Go ahead.
Q. Do you understand the question?
A. I'm sorry. No. Can you say it again, please?
Q. Sure. The reason why the current system is unsatisfactory in some instances to providers is because they're being reimbursed at a lower amount for a branded drug when it's in the same J code as generic competitors than they would if reimbursement was paid directly to that drug's AWP, correct?
A. Well, I would say if it was pegged

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to that drug's NDC number.
Q. And the advantage of pegging it to that drug's NDC number is that it would enable reimbursement to be tied to the AWP for that NDC, correct?
A. Well, we may not necessarily tie it to the AWP. We may have a fee out there for that NDC number. It may not be AWP.
Q. So reimbursement would be tied to a particular branded drug rather than a blended rate of that drug and other generics?
A. Correct.
Q. Would it be a fair statement that reimbursement for a specific branded drug would generally be higher than the current reimbursement which is for that branded drug and generic competitors?
A. Yes.
Q. So, generally speaking, the concern here that a provider is addressing to Anthem is that under the current system they're

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being paid less than they think they should for that branded drug?
A. Yes.
Q. And the advantage to Anthem of moving to an NDC-based system is that it would enable reimbursement to be tied to that particular drug and thereby alleviate those providers' concerns?
A. Correct.
Q. So that would be an advantage that Anthem recognizes even though it would generally be paying more in relation to those particular branded drugs?
A. Yes.
Q. So Anthem sees that as an example of an advantage that would be associated between reimbursing for a particular drug, be it by reference for AWP or some other pricing point for that particular drug, even though it would be paying more?
MR. THOMAS: I'm going to object to the form. I'm going to object to the form.

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Q. Do you understand the question?
A. I guess. Can you say it again, please.
MR. MANGI: Sure. Would you mind reading it back, please.
(Record read as requested.)
A. I'm sorry. Can you do it one more time?
MR. THOMAS: Do you need him to rephrase it?
THE WITNESS: Let's just read it one more time.
(Record read as requested.)
MR. THOMAS: Same objection.
A. Yes.
BY MR. MANGI:
Q. Let's turn to another document, please. We can mark this as Exhibit Spahn 002.
-=0=-
(Exhibit Spahn 002 marked.)
-=0=-

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Q. Could you please review that and let me know when you're done.
A. All right.
Q. Now, the cover page is an agenda that relates to another professional drug reimbursement team meeting, right?
A. Yes.
Q. And you're one of the attendees at this meeting?
A. Yes.
Q. The first agenda item is Procrit/Aranesp update. Do you recall what the particular issue was here relating to Procrit/Aranesp?
A. No, I don't.
Q. Okay. Let's turn to the page with the Bates number, which is the number on the bottom right, 48. Now, this is an e-mail you sent to Dave Prugh, correct?
A. Yes.
Q. Would you remind me what Mr. Prugh's title was?

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A. He's an executive director. I don't know his formal title.
Q. He's an executive director in the provider reimbursement area?
A. In health care management.
Q. Which is the department that you're part of?
A. Yes.
Q. Now, you start this e-mail saying, "Recommended drug pricing formula is WAC plus five percent with a cap."
What is the amount of the cap?
Now, what is this recommended drug pricing formula that you're referring to?
A. These are new drugs, so the drug wouldn't have a J code. So it's really not paid on the fee schedule. They're paid on individual consideration basis. The question was how the -- what do you pay for these things when they're not paid on the fee schedule.
Q. So what has the -- well, when a new

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drug is introduced and doesn't have a J code, it has a miscellaneous code, correct?
A. I think it says, like, unclassified drug.
Q. What was the reimbursement methodology applied to such drugs prior to 2003, which is when this discussion was taking place?
A. I don't know.
Q. What was the methodology used in 2003 at the time this discussion was taking place?
A. Again, I don't know, because, remember, these are not paid through the fee schedule, so I wasn't involved. So I don't know.
Q. Do you know how Anthem currently reimburses for new drugs that don't have the J code?
A. Yes. We're doing the WAC plus five.
Q. So what you do know is that in 2003, Anthem was assessing what it should

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prospectively reimburse for new drugs that don't have a J code, right?
A. Correct.
Q. Were you in charge of that analysis?
A. In charge of it? I think I worked up some of the -- I think I worked up some of the figures.
Q. Okay. And the eventual recommendation for these drugs was WAC plus five percent with a cap, right?
A. Yes.
Q. And that has since been implemented?
A. Not exactly. The WAC plus five has.
Q. Okay.
A. They're not doing the cap.
Q. Okay. How did Anthem arrive at the WAC plus five percent formula?
A. I don't know for sure. You know, really, I don't know.
Q. Okay. Do you know why Anthem decided to use a WAC plus formula rather than an AWP minus formula or something else?

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A. No. Because I think it's basically the same thing.
Q. And you say that because you can start with WAC and add a percentage or start with AWP and minus a percentage and get to whatever number you want?
A. Right.
Q. What was the discussion in relation to having the cap?
A. I don't recall. It had something to do with they thought -- gosh. I don't remember.
Q. Okay. In fact, if we go down to the third paragraph, I think that answers one of the questions I had earlier. "Current drug fees are equal to WAC plus $9.10."
And above that we have a handwritten plus 25 percent.
Do you see that?
A. Yes.
Q. Is that your handwriting, "plus 25 percent"?

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A. Yes.
Q. Do you understand that the formula prior to the date of this e-mail in relation to new drugs that did not have a J code to be WAC plus 25 percent?
A. No.
Q. Okay. So what is your understanding as to what that 25 percent there indicates?
A. Well, I think it means this $9.10 must be 25 percent above WAC.
Q. Okay. So that's a calculation in relation to a specific drug?
A. I don't remember, because it doesn't really say.
Q. Well, you continue, "The markup varies greatly by individual drug."
Do you see that?
A. Yes.
Q. Now, were you referring to the variation as being in dollar amounts, because the WAC was different, so a percentage of WAC would be different, or

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were you referring to the percentage markup being different?
A. I don't remember.
Q. You continue there, "The range is from a low of $2.67 for Procrit to a high of $128.75 for Lupron Depot."
Do you see that?
A. Yes.
Q. Do you know why you used Procrit and Lupron Depot?
A. No.
Q. Is it because Procrit was a low price drug that would be a good example for the lowest costs to Anthem for reimbursement?
A. I don't know.
Q. You continue then, "The break-even point for WAC plus five percent is WAC plus five percent, with a cap of $20."
What do you mean by that?
A. I just -- I don't remember.
Q. Okay. Does reading the rest of that

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paragraph refresh your recollection of what you meant by that, or any of the examples that follow?
A. No. I don't remember this.
Q. So you have no understanding of what you meant there?
MR. THOMAS: I understand. Took me a while.
A. I don't know. I don't remember. I don't even remember doing this.
Q. Okay. Just for the record, my question was, do you have an understanding as to what you were referring to here, what you meant by the break-even point in this paragraph?
A. Well, I guess just what it says, that if you capped it at $20, it would be the same thing as WAC plus five.
Q. In relation to these particular drugs?
A. I don't -- I don't remember.
Q. Okay.

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-=0=-
(Exhibit Spahn 003 marked.)
-=0=-

Q. Let's turn now to this document that's been marked as Exhibit Spahn 003. Please review that and let me know when you're done.
Ready?
A. Yes.
Q. Now, this is another professional drug reimbursement team meeting minutes, right?
A. Yes.
Q. It's from November of '03, and you're one of the attendees, correct?
A. Yes.
Q. Under the agenda item Procrit/Aranesp pricing recommendation, do you see an entry for, "The WAC plus ten percent recommendation was shared with all HSAs"?
Do you see that?

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A. Yes.
Q. Do you have an understanding as to why a particular pricing recommendation was being made in relation to Procrit and Aranesp?
A. No.
Q. Is it your understanding that a particular reimbursement formula was being recommended in reference to these two drugs?
A. I'm sorry? Can you say that again?
Q. Sure. Is it your understanding, based on what's in the discussion column here, that a particular reimbursement methodology, that's WAC plus ten percent, was being recommended in relation to these two drugs, Procrit and Aranesp?
A. Yes.
Q. Was that suggestion/recommendation implemented?
A. I believe it was. I'd have to check. I don't know for sure, but I think so.

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Q. Is WAC plus ten percent a reimbursement methodology that's currently applied to any drugs other than Procrit and Aranesp?
A. Not that I'm aware of.
Q. Is there any information as to why these drugs are being given this particular treatment?
A. My recollection, best I can recall, is that they wanted -- that they wanted the drugs priced the same. They wanted the same fee for both. But I can't remember -- something like the dosing is different, so you had to be careful how you priced. Somehow they wanted them priced the same.
Q. Okay. So you recall that Anthem did want to have the same reimbursement terms or to be paying the same amount in reimbursement for these two drugs?
A. That's my understanding, yes.
Q. And so Anthem decided to recommend a new methodology for these drugs to its HSAs,

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and they, with the exception of Indiana, implemented it?
A. Yes.
Q. Do you know why Indiana was an exception?
A. No, I don't.
Q. Just as Anthem created this special treatment for these two drugs, is it fair to say that Anthem could adjust the reimbursement rates for any of its drugs at any time that it so chose, subject, of course, to existing contracts?
MR. MATT: Objection. Foundation.
A. Yes.
Q. So, indeed, at any point, Anthem could have or can decide that it will reimburse for a particular drug by reference to WAC-based benchmark here or an AWP-based price or any other methodology that it so chooses, right?
A. Yes. But when you change the fee, remember, you have to give notice before you

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do that.
Q. Right. Subject to contractual requirements and notice requirements.
A. Right.
Q. So subject to those qualifications, my statement is correct?
A. Yes.
Q. Now, could you turn to the next page, please. It's Bates number ending 616. And there's an entry for Drug Loading Issues.
A. Yes.
Q. Could you review the discussion column, please. Let me know when you're done.
A. Okay.
Q. Now, it begins, "Joe Spahn raised some concerns regarding the rate loading of drugs that are billed with the NOC code."
What is an NOC code?
A. Not otherwise classified code.
Q. Are these the new drugs that we were

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discussing earlier?
A. They're drugs -- not necessarily new drugs. The drugs that don't have a specific J code.
Q. Okay. And what was the concern that you were flagging here?
A. Well, in reading that, I don't know if someone called this to my attention, but apparently, it came to my attention that there are people who price out the NOC codes, and we should have been following a formula of the WAC-plus strategy. But we also have med review nurses. And I don't recall, but someone must have brought it to my attention that they were using AWP.
The concern was that we were inconsistent in how we were paying these depending on who was pricing them out, what department was pricing them out.
Q. The medical review nurses are Anthem employees?
A. Yes.

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Q. What is their function?
A. I don't even know if I know for sure what their function is. Med review, I guess they review medical --
MR. THOMAS: Don't guess.
Q. Let me focus the question for you. What is their role in relation to reimbursement for drugs?
A. Really, I'd almost say they're not involved in the fee schedules. And I really don't deal with the medical review area. Okay.
I mean, I'm going to -- I don't know if you want me to speculate or just say I don't know.
MR. THOMAS: That depends on what the answer is, Joe. Answer him truthfully. If you don't know, tell him you don't know. If you do know, tell him what you know. If not, I'm going to tell you not to speculate.
A. Well, I don't know.
Q. Okay. Well, let me ask you this:

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Prior to this time, had the WAC plus five percent formula that we saw referenced in an earlier exhibit been implemented for drugs that do not have J codes?
A. I believe so.
Q. Okay. So the concern here was that there was that new methodology was not being consistently applied; is that accurate?
A. Yes.
Q. That's because these medical review nurses were somehow indicating reimbursement would be at an AWP-based percentage?
A. Correct.
Q. You then identified three recommendations. Do you know which, if any, of those were implemented?
A. No, I don't know.
Q. The third of those arrow points is, "Educate the Medical Review nurses on the revised process which includes reviewing the list of new drugs to determine if WAC plus percent pricing has been applied, if not

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then apply AWP."
What's this list that's under discussion here?
A. We have out in Lotus Notes database -- they developed a list of all the drugs that do not have a specific J code and the fee next to it so they can easily reference it without having to look it up every time.
Q. What I'm trying to understand is, if the methodology that was applied was that all drugs that do not have a specific J code will be reimbursed as a WAC plus five percent formula, then what's left? What would be -- in what cases would AWP be applied, as per this paragraph?
A. Well, as I recall, I think the only drugs that are getting the WAC plus five -- I think it first has to be approved by this professional drug reimbursement team. So if it didn't go through this team, it wouldn't be out on that database. So they might get

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a claim in with a drug that's not on the fee schedule, it's not on the database.
Q. So was the idea that this was intended to be an across-the-board strategy, but the database took a while to update to make sure that the strategy was applied to all drugs?
A. Yes.
Q. So in instances where the database had not yet been updated, what methodology was being applied for drugs that did not have a J code?
A. Again, I don't know. I just think it would be an inconsistent.
Q. Was it an AWP-based methodology, per the terms of this paragraph?
A. Well, it would seem like, but I'm not involved with the med review or any pricing of these NOC codes.
Q. So you don't know what percentage off AWP it would have been?
A. No, I don't.

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-=0=-
(Exhibit Spahn 004 marked.)
-=0=-
Q. Let's turn to another document, Exhibit Spahn 004. Have a look at that, and let me know when you're done, please.
A. Okay.
Q. Who is Ms. Alena --
MR. THOMAS: Baquet-Simpson.
MR. MANGI: Thank you.
MR. THOMAS: No problem.
A. She's the medical director for northern Ohio.
Q. Okay. Do you understand this to be a standard form letter?
A. It's not a -- I don't know if I'd use the term "standard letter." But this is the notification -- this is that 45-day notification we talked about.
Q. Okay. Now, this refers to an update to the fee schedule, and particularly changes that are being made as of December

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1st, day after tomorrow, right?
A. Right.
Q. Do you know whether this letter was actually sent out to providers?
A. Why -- well, I didn't send it, so -- I would assume it was.
Q. The first bullet point refers to, "The chemotherapy administrative fees will see a dramatic increase."
Do you see that?
A. Yes.
Q. Now, was that increase limited to chemotherapy drugs, or is this a similar misnomer like we discussed earlier, where the intention is to refer to all drugs administered in physicians' offices?
A. All drugs.
Q. So the intention here was to refer to all drugs administered in physicians' offices and to reference the fact that the administration fees are being increased?
A. That's correct.

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Q. What's the basis for the increase in administration fees starting on December 1st, 2004?
A. Can you define what you mean by "basis"?
Q. Why the admin fees being increased as of the day after tomorrow?
A. Because the drug fees were going to be decreased.
Q. And the drug fees -- what's the change in the drug reimbursement methodology that you understand is leading to a decrease?
A. Because we were going to 100 percent of Medicare. It says, 100 percent of the June 2004 Medicare drug fees.
Q. So was there a change -- is there a change being implemented as of December 1st in the percentage of the CMS fee schedule that would be reimbursed to providers?
A. Yes.
Q. What is the change?

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A. Remember, this is northern Ohio. Northern Ohio was paying 105 percent of the January 2002 Medicare drug fees. And they're going to 100 percent of the June 2004. That's right. June 2004.
Q. So are the changes that there's a change in the percentage of the Medicare fee schedule that Anthem is reimbursing and also a change in the actual fee schedule?
A. Okay. Can you say that one again?
Q. Sure. The percentage of the fee schedule that's being reimbursed in the region to which this letter was sent is being changed --
A. Can I stop you for a second? When you say "the percentage," that's -- we don't pay a percent of the fee schedule. We pay the whole fee --
Q. Perhaps I'm using percent loosely. 105 percent of the fee schedule was being paid previously.
A. 105 percent of Medicare's fee

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schedule was being paid.
Q. Right. So a fee schedule plus a percentage?
A. The fees that we had loaded were 105 percent of Medicare.
Q. Okay. And that's now being shifted to 100 percent?
A. To 100 percent. That's correct.
Q. Now, is that change from 105 percent to 100 percent the only reason for this dramatic increase in admin fees?
A. Yes.
Q. There are no other reasons going into it?
A. I don't believe so.
Q. Is it anticipated that there will be further increases in the fee schedule as Medicare moves towards an ASP plus six percent formula?
A. I don't know.
Q. The second bullet there is referencing a point we had been discussing

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earlier, which is new drugs that don't have a J code --
A. Right.
Q. -- will be reimbursed plus five percent?
A. Right.
MR. MANGI: Why don't we take another quick break.
(Recess taken.)
BY MR. MANGI:
Q. Have you ever seen any of Anthem's contracts with providers?
A. Yes.
Q. Okay. Do you utilize those contracts in your day-to-day business?
A. No.
Q. In what circumstances have you seen Anthem's contracts with providers?
A. Just in the casual -- kind of a casual way. But I don't do anything with them or use them.
Q. Do you play any role in the drafting

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of those contracts?
A. No.
Q. Do you know whether or not fee schedules are actually appended to those contracts?
A. I don't believe they are.
Q. Do you know whether fee schedules are provided to physicians?
A. On request, yes.
Q. So a physician has to ask for a copy of the fee schedule before it's provided to him?
A. Yes.
Q. Where he does not so request, all the physician receives are the reimbursement that Anthem pays for the claims that he submits?
A. Again, I'm not sure. That's probably something that management would know.
Q. Are you familiar with a program called the Equality Improvement Program?

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A. No.
-=0=-
(Exhibit Spahn 005 marked.)
-=0=-
Q. Can you take a moment to acquaint yourself with that, please, and let me know when you're done.
The Bates numbers for this document which has been marked as Exhibit Spahn 005 are from A-0H05010559 until 571.
Have you ever seen this type of document before?
A. No.
Q. By Professional Provider Agreement, you understand this to be a contract with a physician or physician's group?
A. Yes.
Q. I draw your attention to page 4 of the document. Do you see 2.13 referring to a Separate Provider Network?
A. Okay.
Q. Do you know how many provider

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networks Anthem has at present?
A. No.
Q. Do you know whether there are specific provider networks that are -- that provide services pursuant to a particular product or plan?
A. No.
Q. Referring to page 5, 3.3, Submission of Claims. That refers to the submission of claims either approved forms or electronically.
Do you see that?
A. Yes.
Q. Do you know whether one or both of those options are currently in use by different providers?
A. Both are.
Q. So some submit hard copy forms and some submit electronically?
A. Yes.
Q. Is there any difference in reimbursement depending on manner of

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submission other than the time period?
A. No.
Q. Turn to page 6, please. 3.12, Blue Cross/Blue Shield Out of Area Program.
A. Yes.
Q. Are you familiar with that program?
A. No.
Q. Do you have an understanding as to whether or not Anthem has any sort of reciprocal or other arrangements with other Blue Cross/Blue Shield plans for reimbursement?
A. Not that I'm aware of.
Q. Turn to page 10, please. There's a clause there, 8.2, entitled Amendment, which reads, "Anthem retains the right to amend this Agreement, Anthem Rate, the Provider Manual, any attachments or addenda, the Quality Improvement Program or Utilization Management Program, by making a good faith effort to provide notice to Provider..." Then it continues.

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Are these the notice requirements you were referring to earlier when we spoke about Anthem changing its reimbursement methodologies?
A. Yes.
Q. So provided Anthem complies with these sorts of requirements, it could at any time decide to change its reimbursement methodology from one or more drugs to a WAC-based formula to some other type of formula?
MR. THOMAS: Objection.
A. Yes.
Q. And indeed it could have done so in the past?
MR. THOMAS: Same objection. Go ahead.
A. Yes.
MR. THOMAS: I have to do it quickly or you're going to answer before I get my objection out.
Q. Are you familiar with professional

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provider agreement manuals?
A. No.
Q. Turning to the last exhibit we just looked at. Turning back to Exhibit Spahn 005. Do you understand this to be a template for a contract rather than a contract?
A. No, I don't know.
Q. Well, you see that the effective date is blank, and the signature page at the back is also blank; is it not?
MR. THOMAS: I believe it was produced as an exemplar. I do not believe it was a specific contract. I can answer that.
Q. Do you have an understanding as to whether or not all professional provider agreements at present have the same terms as this one?
A. I don't know.
Q. So you have no knowledge as to whether or not this contract is representative of all of Anthem's provider

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agreements at present?
A. No, I don't.
Q. Do you have an understanding as to whether or not this form of this contract has changed over time?
A. I don't.
MR. MANGI: Let's mark this exhibit as A-OH05020138 to 5020146.
-=0=-
(Exhibit Spahn 006 marked.)
-=0=-
Q. Would you please take a moment to review that. Let me know when you're done.
A. All right.
Q. Now, this contract template bears the heading Community Insurance Company. Do you understand this to be a pre-1995 template?
A. I would think so, yes.
MR. MANGI: Okay. I see counsel is shaking his head. Would counsel like to represent --

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MR. THOMAS: I'm not sworn in. Do you want to go off the record and talk about our corporation history? I'll be happy to. But I'm not going to talk about it on the record.
MR. MANGI: Sure. Let's go off the record.
(Discussion is held off the record.)
BY MR. MANGI:
Q. Turning to page 2 of the contract. Do you see a Clause VB, The CIC Rate?
A. VB?
Q. Right.
A. Yes, I got it.
Q. Now, that seems to imply that the fee schedule is actually attached to these contracts.
A. Well, but this is a hospital, right? This is a facility.
Q. Right. So for hospitals, fee schedules are attached, and for providers they're not; is that a fair statement?

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A. Again, I don't know, because I don't work in contracts.
Q. Okay. If you look to Clause D below that, this provides for a renegotiation of the rate.
MR. THOMAS: I'm sorry. Go ahead.
A. Yes.
Q. And pursuant to this, you, which is the facility, agree to submit financial and other information deemed necessary by Anthem. Do you see that?
A. Yes.
Q. Do you know whether or not such negotiations have taken place?
A. No, I don't.
Q. Do you have any information as to the type of financial information that Anthem would request in such renegotiations?
A. No.
Q. Does that all pertain to the hospital area which you're not involved with?

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A. I don't know if all pertains to hospital or not. I'm not involved with that.
Q. Okay. Could you turn to page 8, please. This provides for -- it says the CIC cover rate is blank percent of the following. And then in relation to IVs, there seems to be a formula for a dollar amount plus a percentage of AWP. Do you see that?
A. Yes.
Q. Do you know -- if you flip back to page 7, you will see that this -- the exhibit offers this schedule as a part referring to home infusion therapy.
MR. THOMAS: I'm sorry. Could you restate that?
Q. Yeah. If you flip back to page 7, which is the previous page, you'll see the heading refers to home infusion therapy providers.
A. Yes.

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Q. Do you know whether this use of AWP-related formula is limited to that home infusion realm or whether it's applied more generally to facility reimbursement?
A. I don't know.
-=0=-
(Exhibit Spahn 007 marked.)
-=0=-
Q. Take a look at Exhibit Spahn 007, please. Let me know when you're done. I'll have a very specific question about this document when you're ready.
A. All right.
Q. Now, on the very first page of this document you'll see that Community Insurance Company is referred to as "we" or "us." Do you see that?
A. Yes.
Q. And the provider or the facility here is referred to as "you." See that?
A. Yes.
Q. Now, if you could flip over to the

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page marked ADD-B-5.
A. Okay.
Q. At the bottom of the page on fee schedule, it says, "you," meaning the facility, shall provide "us," meaning CIC, with a copy of your fee schedule on an annual basis.
Now, this seems to suggest that a fee schedule that's created by the facility is being used rather than a fee schedule created by Anthem. Can you clarify what that clause is referring to?
MR. MATT: Object to that question. No foundation.
A. No.
MR. THOMAS: He said no, he can't.
Q. Do you have any understanding as to whether Anthem receives fee schedules from facilities?
A. No, I don't.
Q. Do you have any knowledge as to whether Anthem makes any reimbursement to

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any entities based on fee schedules other than those that it generates?
A. No, I don't.
Q. Now, earlier we saw an exhibit that was a template for a professional provider agreement. Do you remember that heading?
A. Yes.
Q. There are other agreements that have been produced by Anthem that are captioned "ancillary provider agreements."
Do you have any understanding of the difference between a professional provider and an ancillary provider?
A. Technically, I don't know, but I -- ancillary provider is usually more of a facility. I mean, they usually do a UB92 claim form.
Q. So you understand an ancillary provider to be a hospital?
A. I don't think it's necessarily a hospital.
Q. Do you understand it to be something

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other than a physician's office?
A. Yes.
Q. What would it be, if not a hospital?
MR. THOMAS: I'll object to the form of the question. I think he suggests he's not real clear on what it might be.
Q. If that's the answer, that's the answer.
Do you know what sort of facilities would be encompassed by that other than a hospital?
A. No.
MR. MANGI: Okay. I'm done. Questions, Sean?
MR. MATT: I have a couple follow-up questions, Mr. Spahn, for the record.
EXAMINATION
BY MR. MATT:
Q. Again, I'm counsel for plaintiffs in this case.
Did I hear you earlier state in response to a question that drugs represent

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only three percent of the total physician reimbursement?
A. Correct.
Q. Earlier you had a colloquy with Mr. Mangi regarding the movement for reimbursement based on J code to reimbursement based on NDC. Do you recall that testimony?
A. Yes.
Q. I believe the testimony was something to the effect a move to AWP would increase the reimbursement amount for a brand name drug because presently the brand name drug, because it's reimbursed by J code, may be reimbursed on a blended rate of generics and brand names. Is that correct?
MR. MANGI: I'll object.
A. I'm sorry. Can you --
Q. Let me see if I can't answer that question -- or ask that question a little bit more in a logical step-by-step format.
J code -- you testified earlier that

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reimbursement based on J code is a blended rate of brand and generic, correct?
A. Correct.
Q. A move to AWP would increase the reimbursement amount for a brand name drug, correct?
A. One more time.
Q. That a move to AWP would increase the reimbursement?
MR. MANGI: Object.
MR. THOMAS: Object to foundation. I don't think he said AWP. I think he said NDC.
MR. MATT: NDC. Thank you for the clarification.
Q. NDC would increase the reimbursement amount for the brand name drug, correct?
A. Correct.
Q. Would it also lower the reimbursement amount for the generic drug?
A. It possibly could, but not to the extent it would increase for the brand name.

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Q. Okay. Thank you for that clarification.
Under the present reimbursement formula Anthem uses for drugs administered by a physician, if the average wholesale price increases, the cost to Anthem increases, correct.
MR. THOMAS: Foundation. Go ahead.
A. Well, I'm sorry. I hate to keep -- can you say that one more time?
Q. Sure. Under the present reimbursement formula, and the regions of Anthem with which you are familiar, if the average wholesale price is increased for a drug, the cost to Anthem of reimbursement increases, correct?
A. None.
Q. Why is that?
A. Because we have a set fee schedule. So it doesn't matter what the AWP does, unless we change our fee.
Q. Unless you change your fee, which

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you do annually, correct?
A. Well, it's reviewed annually. A decision as to whether they want to change --
Q. If they don't --
MR. THOMAS: Wait. Are you finished, Joe? Go ahead, finish your question.
A. It's a decision of the reimbursement teams and the people in network management if they actually want to change them or not. So they can be reviewed and not changed.
Q. Let's take an example of when Anthem makes a decision to maintain the reimbursement percentage of the Medicare schedule. Let's say it's 100 percent. If the reimbursement -- if the Medicare reimbursement schedule for a particular drug increases, that increases the cost to Anthem, correct?
A. Not necessarily. Again, we may -- just because Medicare changes the fee,

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doesn't mean we will.
Q. In an instance in which the example I'm pursuing is 100 percent of the fee schedule -- if Anthem has made a decision it's going to reimburse 100 percent of the fee schedule. If the Medicare fee schedule rate increases, the Anthem rate's going to increase, if Anthem's not made a decision to change, correct?
A. Well, not necessarily.
MR. THOMAS: Off the record just one second.
(Discussion is held off the record.)
BY MR. MATT:
Q. Let's use the example of a change in the Medicare fee schedule. Let's say Medicare fee schedule increases the reimbursement for a particular drug from one year to the next. Anthem doesn't change its reimbursement percentage. That increases the cost to Anthem, correct?
A. Not necessarily. No. Maybe we need

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to be very clear. We have a fee schedule. So you have the procedure code and a fee. We don't have Medicare's fees loaded and then pay a percent of that Medicare fee. Do you understand the distinction I'm trying to make? So if we have a fee for that code of $100, and let's say that $100 is based on 100 percent of Medicare's 2003 allowance, come 2004, Medicare increases their fee, we may not change our fee at all.
So just because Medicare goes up or down or whatever doesn't necessarily change our fees.
Q. Thank you for the clarification.
MR. MATT: That's all I have. Thank you.
MR. MANGI: I have nothing further.
MR. THOMAS: We'll read.
-=O=-
Thereupon, the testimony of November 30, 2004, was concluded at 1:54 p.m.

CERTIFICATE

STATE OF OHIO :

SS:

COUNTY OF FRANKLIN :

I, Rhonda Lawrence, RPR/CRR, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named JOE SPAHN was first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced to stenotypy in the presence of said witness, afterwards transcribed; that the foregoing is a true and correct transcript of the testimony; that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of any of the parties hereto; that I am not a relative

or employee of any attorney or counsel employed by the parties hereto; that I am not financially interested in the action; and further, I am not, nor is the court reporting firm with which I am affiliated, under contract as defined in Civil Rule 28(D).

In witness whereof, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this day of , 2004.

Rhonda Lawrence, RPR/CRR
Notary Public, State of Ohio.
My commission expires: September 25, 2008